DOCUMENT RESUME

ED 482 759 CG 032 754

AUTHOR	Wimmer, Mary B.
TITLE	School Refusal: Assessment and Intervention within School Settings.
INSTITUTION	National Association of School Psychologists, Bethesda, MD.
ISBN	ISBN-0-932955-81
PUB DATE	2003-00-00
NOTE	99p.
AVAILABLE FROM	NASP, 4340 East West Highway, Suite 402, Bethesda, MD 20814 (ISBN-0-932955-81-9, $19). Tel: 301-657-0270; Fax: 301-657-0275; Web site: www.nasponline.org.
PUB TYPE	Books (010) -- Information Analyses (070)
EDRS PRICE	EDRS Price MF01 Plus Postage. PC Not Available from EDRS
DESCRIPTORS	*Anxiety; *Behavior Disorders; Early Identification; Educational Environment; Intervention; *School Phobia; *School Psychology; Student Evaluation
IDENTIFIERS	*School Refusal

ABSTRACT

Anxiety-based school refusal occurs in 2% of school-age children. The reasons why they refuse to go school range from mental illness and learning problems to general defiance and a desire for attention. Early identification and multi-faceted assessment and interventions are critical to addressing the problem. This book offers concise, practical guidance on assessment and interventions to help children with anxiety-based school refusal. The author incorporates the latest research findings and discusses causes, warning signs, and various strategies for working with children within a school setting and for communicating with parents and teachers. Chapters cover: understanding school refusal, history and etiology, identification and assessment, interventions, case illustration, and sample forms and handouts. (Contains 143 references.) (GCP)

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SCHOOL REFUSAL

ASSESSMENT AND INTERVENTION WITHIN SCHOOL SETTINGS

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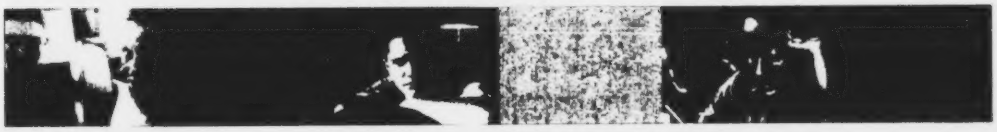

MARY B. WIMMER, PH.D.

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Copies may be ordered from:
NASP Publications
4340 East West Highway, Suite 402
Bethesda, MD 20814
(301) 657-0270
(301) 657-0275, fax
e-mail: *publications@naspweb.org*
www.nasponline.org

ISBN 0-932955-81-9

Printed in the United States of America

First Printing, Spring 2003

10 9 8 7 6 5 4 3 2 1

From the NASP Publications Board Operations Manual
The content of this document reflects the ideas and positions of the authors. The responsibility lies solely with the authors and does not necessarily reflect the position or ideas of the National Association of School Psychologists.

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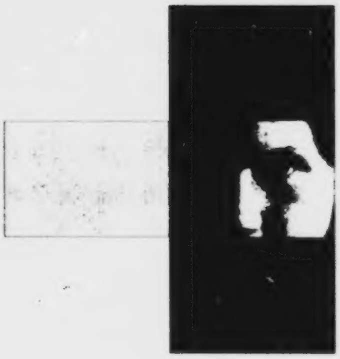
ACKNOWLEDGMENTS

I would like to thank the reviewers of this book, Christopher A. Kearney, Leslie Z. Paige, and Kristine Sieckert for all the time they spent reading the chapters, their invaluable feedback, and thoughtful editing. I am grateful to Servio Carroll, Nancy Metzler Peterson, and the NASP publications board for supporting the development of this update of Leslie Zeldin Paige's book, *The Identification and Treatment of School Phobia* (1993). Special thanks to Marilyn Brazier, Linda Morgan, and everyone at the National Association of School Psychologists for all their help in putting the pieces together. Thanks also to Mike Schwartz for his careful copyediting. I especially want to thank my husband, Mike Fleissner, for being a first reader on this project. Finally, this book is dedicated to the children and adolescents, researchers, school psychologists, and other mental health professionals who have helped us to understand and effectively address this complex problem.

AUTHOR'S NOTE

Names and other identifying details of cases presented by the author have been changed to protect confidentiality.

Mary Wimmer has worked as a school psychologist in southeastern Wisconsin for 20 years. She is also an adjunct lecturer in the Education Department at Carroll College in Waukesha, Wisconsin.



CHAPTER 1

UNDERSTANDING SCHOOL REFUSAL

Cody fights with his mother every morning before school. He hides under his bed, refusing to come out. Eventually his mother has to carry him to the car only to endure another round of kicking and crying in the school parking lot. Cody's third grade teacher tries to prevent his running out of the classroom when his mother leaves the building.

School refusal behavior presents challenging and often agonizing scenarios for parents, students, and teachers. While initial or occasional apprehension regarding school attendance is regarded as normal, a significant problem occurs when anxiety results in refusal to attend school (King, Ollendick, & Tonge, 1995; Ollendick & Mayer, 1984). School refusal refers to primarily emotionally based absenteeism initiated by the child and includes children who exhibit extreme anxiety surrounding school attendance, usually the result of an anxiety disorder (Burke & Silverman, 1987; Last, Hansen, & Franco, 1998; Last & Strauss, 1990). The broader term, school refusal behavior, includes children with emotionally based school refusal described above as well as those traditionally referred to as truant (Kearney, 2001; Kearney & Silverman, 1996). As such, school refusal behavior is defined as a repetitive pattern of nonattendance initiated by the child which may involve missing school for full days, part of the day, or school attendance only after severe acting out with the intention to miss school (Kearney, 2001).

The task of defining and classifying school refusers is difficult because school refusers are a heterogeneous group of children who experience an array of internalizing features such as separation anxiety, social anxiety, and depression (Bernstein & Garfinkel, 1986, 1988; Bernstein et al., 1997; Last, Francis, Hersen, Kazdin, & Strauss, 1987; Last & Strauss, 1990). For some school refusers, externalizing behaviors are present and are manifestations of severe anxiety (Kearney, 2001). For example, like Cody, panic at being separated from a caregiver results in acting out behaviors such as screaming, clinging, or kicking. Additionally, there are several variables that contribute to or exacerbate school refusal behaviors. Contributing variables to school refusal include family pathology, victimization, poor teacher-student relationships, or academic difficulties (Kearney, 2001; King et al., 1995).

TERMS ASSOCIATED WITH SCHOOL REFUSAL

Anxiety-based school refusal refers to children who experience extreme anxiety surrounding school attendance. Over the years, researchers have used many terms to describe these children. Terms associated with anxiety-based school refusal are "psychoneurotic truancy," "school phobia," and "school refusal."

Early psychodynamically oriented writers used the term "school phobia" to refer to extreme anxiety surrounding separation from a parent, usually the mother (Johnson, 1957). However, use of the term school phobia has been described as inaccurate when what is really being referred to is a child's separation anxiety. More precisely, the term school phobia refers to a fear of school or something associated with school (e.g., the school building, the fire alarm) whereas separation anxiety refers to a child's difficulty separating from one or both parents (Burke & Silverman, 1987). Additionally, the term school phobia suggests the presence of a specific phobia toward a school situation that may be present for some children yet for others may more accurately be described as social or performance anxiety (Kearney & Beasley, 1994).

Indeed, there has been growing recognition that emotionally based school avoidance can be the result of not only separation anxiety but features such as social anxiety and depression. Accordingly, the more inclusive term, "school refusal," began to be used by some practitioners and researchers because it encompasses the wide range of etiologic and interacting variables that result in attendance problems (Burke & Silverman, 1987; King et al., 1995). For example, the impetus for an adolescent who stays home to avoid giving a speech is related to performance anxiety. This scenario differs from the child who balks at going to school because of a fear that something bad is going to happen to a parent. Yet for both students, the demands for school attendance create intense anxiety and avoidance responses. The term school refusal is used here to refer to emotionally based school avoidance (i.e., primarily the result of anxiety or depression).

The primary focus of this book will be anxiety-based school refusal though a wide range of etiologic variables and associated intervention strategies will be covered.

Children with anxiety-based school refusal have historically been identified as distinct from those students exhibiting characteristics associated with delinquent truancy. Delinquent truancy refers to students who skip school without their parent's knowledge and engage in delinquent behaviors. These children lack the emotional difficulties typical of children identified as having anxiety-based school refusal. Similarly, the term "truancy" is defined as unexcused absence without parent's knowledge (Berg et al., 1985) in the absence of somatic complaints with poor academic progress, and possible antisocial behavior (Pilkington & Piersel, 1991). Additionally, the term truancy is sometimes used by school personnel to refer to unexcused absence from school in violation of compulsory attendance laws regardless of the reason for the absence (e.g., emotional, motivational, or delinquent).

Kearney (2001) points out that some children exhibit emotionally based school refusal combined with the traditional conceptualization of truancy (e.g., Bernstein & Garfinkel, 1986). An example of this combination would be an adolescent who displays comorbid depression and anxiety as well as oppositional behaviors. Features may include a pattern of refusing to get out of bed in the morning, a sense of pervasive unhappiness, panic-like symptoms when verbal participation is required in class, frequent arguing with parents, and skipping classes to hang out with friends and experiment with drugs. In these situations, school refusal represents the tip of the iceberg when educators sift through the many variables that often present as a crisis point for student and family. As previously discussed the term, "school refusal behavior," includes anxiety-based school refusal, behaviors traditionally associated with truancy, or both (Kearney, 2001).

A final term to consider is "school withdrawal." School withdrawal refers to situations where a parent or legal guardian purposely keeps a child home. In these cases, the reason for keeping a child home is initiated by the parent. School withdrawal initiated by the parent includes using a child as a support person for a parent who is anxious and/or depressed, sabotaging efforts to reintegrate a child who has been absent due to school refusal, or requiring a child to work to help with finances (Berg et al., 1985; Kearney, 2001). Table 1 on page 4 summarizes terms and definitions associated with school refusal and truancy.

PREVALENCE RATES

Attendance officers, school secretaries, and school nurses are often among the first to recognize students who are frequently absent or tardy. Teachers will recognize patterns of

TABLE 1

TERMS ASSOCIATED WITH SCHOOL REFUSAL AND TRUANCY

Term	Definition
Psychoneurotic truancy	Once described anxious children who had difficulty separating from an overprotective parent (Partridge, 1939).
School phobia	First used to describe children with excessive anxiety attending school brought on by separation anxiety (e.g., Johnson, Falstein, Szurek, & Svendsen, 1941). Later clarified to refer to a fear of school itself or a phobic reaction to some aspect of school (Burke & Silverman, 1987).
Separation anxiety	Refers to "excessive anxiety concerning separation from the home or from those to whom the person is attached" (American Psychiatric Association, 1994, p. 110).
School refusal	Refers to children who exhibit severe emotional distress about attending school usually due to anxiety.
Truancy	Refers to children who miss school in violation of compulsory school attendance laws. Absence from school is unexcused, generally without the parent's knowledge, and may involve delinquent behaviors.
School refusal behavior	A broad term used to refer to behaviors associated with both emotionally-based school refusal and truancy (Kearney, 2001).
School withdrawal	Refers to when a parent removes a child from school that may be due to a parental need (e.g., the child is the support person for an anxious or depressed parent, to cover up signs of maltreatment, or the student is required to work to help with family finances).

absentee behavior quite quickly, and parents can provide pertinent information related to why their child misses or is late for school. Interestingly, parents do not always communicate why their child is absent or tardy. For instance, a student who stayed home because of a stomachache related to anxiety about school may be reported simply as ill, or students who complain to parents about going to school and attend only with prodding or battles may go entirely uncounted in prevalence rate estimates. Additionally, since it is sometimes difficult to distinguish between anxiety-driven school refusal and truancy, prevalence rates have historically been difficult to compile.

In 1965, Kennedy estimated the school phobia prevalence rate to be at 1.7%. Later, Granell de Aldaz, Vivas, Gelfand, and Feldman (1984) surveyed 1,034 Venezuelan children ages 3–14 years. When they combined high absenteeism with either parent, teacher, or child report of extreme fear associated with school, 5.4% of the sample could be considered school refusers. A lower rate of 0.4% was reported when using a stricter criteria requiring that all three informants report extreme fear of school combined with high absenteeism.

Burke and Silverman (1987) reviewed prevalence rates of school refusal and found a rate of 1% in the general population of school age children and approximately 5% of children referred to clinics. Clinical prevalence rates reported by Kearney and Beasley (1994) were only slightly higher at 6.08%. This sample included responses from 63 professional psychologists.

A survey of 288 school principals in North Dakota by Stickney and Miltenberger (1998) found an estimated 2.3% of students in grades kindergarten through 12 engage in school refusal behavior. This survey did not distinguish between truancy and emotionally based school refusal (the presence of anxiety or depression).

Kearney (2001) compiled comprehensive data on four broad-based components of school refusal behavior. He concluded that when anxiety-based school refusal estimates (1.7–5.4%) were combined with truancy-related estimates (complete and illicit absence from school, partial absence-class cutting, tardiness) roughly 5–28% of children display some aspect of school refusal behavior.

Researchers worldwide have studied school refusal, contributing to an extensive accumulation of literature on the topic. Extensive research has been conducted in England (e.g., Berg & Jackson, 1985; Berg, Nichols, & Pritchard, 1969; Blagg & Yule, 1984; Hibbett & Fogelman, 1990). Studies have also been conducted in Australia (e.g., King et al., 1998); France (Martin, Cabrol, Bouvard, Lepine, & Mouren-Simeoni, 1999); Sweden (Flakierska, Lindstrom, & Gillberg, 1988); and Venezuela (Granell de Aldaz et al., 1984). Though rates are lower in Japan than in the United States, researchers in Japan report concern that the number of students exhibiting school refusal is increasing with more than 127,000 cases reported in 1998 (Kameguchi & Murphy-Shigematsu, 2001).

SUBTYPES AND FEATURES OF SCHOOL REFUSAL

The extreme heterogeneity of this population has led to ongoing attempts to refine classification systems. The resulting array of diagnostic models reflects the complexity of this undeniably diverse group of children. Typically, researchers have assigned subtypes as a framework for classification of school refusal behavior. The earliest subtypes made the distinction between acute versus chronic school phobia and school phobia versus truancy.

Subtyping continues to be practiced by contemporary researchers approaching school refusal behavior from functional, categorical, and dimensional perspectives. A functional approach addresses the function or reason behind school refusal behavior. A categorical approach is geared toward classification of emotional or psychological characteristics of students such as social and separation anxiety or depression. A dimensional approach examines internalizing versus externalizing behaviors. A working knowledge of multiple diagnostic perspectives is critical for school psychologists seeking to understand the impetus for a student's school refusal.

ACUTE AND CHRONIC DISTINCTIONS

A distinction between acute and chronic school refusal was made by Coolidge, Hahn, and Peck (1957), who grouped children with school phobia into two subtypes: neurotic and characterological. Younger children comprised the neurotic group, where school phobia onset was sudden and intense with panic-like symptoms. Older children comprised the characterological group, where symptoms developed gradually, the result of a "deeper character disturbance existing from an early age" (p. 297). With both types, the mother was thought to encourage dependency in the child. This fostering of interdependency was considered more pathological on the part of the mothers of the characterological type, whose symptoms were thought to be part of a more complex personality disorder (Paccione-Dyszlewski & Contessa-Kislus, 1987).

Kennedy (1965), expanding on the concept of subtyping school refusal based on severity, identified 10 symptoms that differentiated between what he termed Type 1 and Type 2 school phobia. Type 1 represented younger children with first episode, acute onset, and for the most part well adjusted and understanding parents. Type 2 represented older children, second, third, or fourth episode school refusal, "incipient onset," and "parents very difficult to work with" (p. 286). Type 1 cases were reportedly responsive to rapid treatment and may have spontaneously improved without treatment.

A continuum of severity using length of time absent from school was developed by Kearney and Silverman (1996). The continuum is useful with all types of school refusal scenarios. It recognizes that some mild cases of school refusal spontaneously remit while others present as long-term problems that last more than one year. A kindergartner's school refusal due to separation anxiety that resolves itself within two weeks with minimal intervention would be considered self-corrective school refusal. A high school student's one year on and off absences due to depression and social anxiety would be placed on the acute end of the continuum. Chronic school refusal is defined as lasting longer than one year.

Exclusionary factors are important considerations and include legitimate illness, situational hardships such as homelessness or running away to avoid abuse and children whose parents keep them home as in cases of school withdrawal (Kearney & Silverman, 1996). Additionally, a parent may keep a child home from school for a period to cover up signs of abuse. Other parents opt to home school their child as a last resort after weeks or months of trying unsuccessfully to get their child to go to school.

ANXIETY-BASED SCHOOL REFUSAL VERSUS TRUANCY

As was previously discussed, a distinction is often made between anxiety-based school refusal and truancy (Berg et al., 1985; Berg et al., 1969; Gordon & Young, 1976; Hersov, 1960; King et al., 1995). In 1969, Berg et al. proposed criteria for school refusal that clearly distinguishes emotionally based school refusal from truancy and continues to be used by some researchers (e.g., King et al., 1998):

- *Severe difficulty in attending school*—often amounting to prolonged absence.
- *Severe emotional upset*—shown by such symptoms as excessive fearfulness, undue tempers, misery, or complaints of feeling ill without obvious organic cause on being faced with the prospect of going to school.
- *Staying at home with the knowledge of the parents*, when they should be at school, at some stage in the course of the disorder.
- *Absence of significant anti-social disorders* such as stealing, lying, wandering, destructiveness and sexual misbehavior. (p. 123)

As illustrated here, children with anxiety-based school refusal typically are not involved in anti-social behaviors and do not conceal their absences from their parents. They exhibit distress surrounding school attendance and frequent physical complaints. Studies investigating large groups of school refusers support the premise of two distinct subgroups of students who avoid school: students with emotional problems such as anxiety and/or depression and those who engage in acting out or delinquent behaviors (e.g., Bernstein & Garfinkel, 1986; Kearney & Silverman, 1996; Last & Strauss, 1990).

Conversely, some students included in studies of school refusers exhibit comorbid anxiety and oppositional defiant disorder (Kearney & Silverman, 1996; King et al., 1998; Last et al., 1998). For example, Kearney (as cited in Kearney and Silverman, 1996) reported that of a sample of 64 school refusers, 6.3% had a diagnosis of oppositional defiant disorder that was comorbid with an anxiety disorder.

TRUANCY AND SCHOOL DROPOUT

Voluminous research has been conducted on the broad topics of truancy and its link to school dropout. A commonly cited theme in the literature indicates that students who drop out of school feel alienated from peers and teachers. Finn (1989) identified a lack of participation in school activities and identification with school as contributing to truancy and later dropout. Another contributing variable is the complaint that teacher expectations are too low for children who have been identified as high risk (Kagan, 1990).

Truancy and school dropout have been associated with high rates of retention in earlier grades (Kortering, Hess, & Braziel, 1997). For some students, years of difficulty with schoolwork lead to a sense of discouragement. Much of the time, disengagement from school can be traced back to elementary school, leading Finn (1989) to describe dropout as a process rather than a discreet decision. Accordingly, Doll and Hess (2001) call for educators to address the "emerging disengagement from schooling evidenced among some elementary school students" early on rather than waiting to intervene in high school (p. 353).

A more thorough discussion of risk and resiliency factors associated with truancy and school dropout is beyond the scope of this book. The reader is referred to Gutkin (2001) and Kortering et al. (1997) for in-depth examination of the topic.

Given the legal requirements under compulsory school attendance laws, some children with emotionally based school refusal are referred to the courts for truancy by school officials. For example, Bernstein and Garfinkel (1986) studied 26 chronic school refusers, ages 9–17 years, and found that 21 met criteria for either an anxiety or affective disorder or both. Of the 26 children included in the study, 42% had been charged with truancy. Bernstein and Garfinkel observed that pressure resulting from court referral was often helpful in getting the child in for evaluation.

A FUNCTIONAL APPROACH TO CLASSIFICATION

Much of the most recent literature published on classification of school refusal behavior is in the area of functional approaches (e.g., Evans, 2000; Kearney, 2001). Functional subtypes of school refusal behavior are based on factors that motivate the child to want to stay home. Of primary importance is an analysis of the cause or function of the child's behavior. One such functional conceptualization, proposed by Kearney and Silverman (1990, 1996, 1999), outlines four subtypes of school refusal behavior. The four subtypes are based on motivating variables for the school refusal behavior and are further defined by whether the behavior is reinforced through negative reinforcement (the behaviors are reinforced by avoidance of unpleasant situations) or positive reinforcement (the behaviors are positively reinforced outside of the school setting through gaining attention or rewards).

The first group, *children who refuse school in order to avoid stimuli that result in negative affectivity,* are those who traditionally fall under the school phobia, separation anxiety construct and includes children who refuse school because of fear, anxiety, depression, and/or somatic complaints. The function or cause of the school refusal behavior is the child's desire to avoid anxiety-producing situations such as being separated from a loved one. The behavior of staying home is negatively reinforced through a pattern of avoidance of aversive feelings and cognitions.

The second group, *children who avoid school to escape social and/or evaluative situations at school,* are children who are socially anxious. As with the first group, the child seeks to avoid or escape fear- or anxiety-provoking situations. The function or cause of the school refusal behavior is the child's desire to escape social or performance situations that cause extreme anxiety (giving a speech, taking a test, socializing with peers).

The third group, *children who primarily avoid school to gain attention,* seek positive reinforcement from family members or others in their environment. These children may have separation anxiety that is exaggerated to gain attention. They can be manipulative, defiant, and engage in acting out behaviors (tantrums, screaming, running away). These children are generally younger in age.

The fourth group, *children who refuse school to seek tangible reinforcement outside of school,* are those children who skip school to engage in activities they consider more reinforcing such as watching television, sleeping, playing video games, or engaging in illegal activities such as drug use (Kearney, 2001). Kearney points out that although these youngsters typically do not exhibit emotional problems like anxiety or depression, negative affectivity may develop after they have been absent from school for a time. These children tend to be older and demonstrate higher rates of externalizing behaviors.

Some overlap among the subtypes is expected (Kearney, 1993). A child who initially stayed home to watch television or play video games may develop anxiety about going back to school to face peers and teachers. A child who stayed home because of separation anxiety may gain positive reinforcement at home by being allowed to play and gain attention from parents.

Kearney and Albano (in press) studied a sample of 143 children to determine diagnoses associated with each of the four functional categories. The children, ages 5–17 years, presented with general school refusal behavior (not solely anxiety-based) at two clinics specializing in the assessment and treatment of school refusal behavior. Results were that anxiety disorders were generally more closely associated with negatively reinforced school refusal behavior (children who avoid school due to anxiety or depression and those who wish to escape aversive social or evaluative situations). Separation anxiety was associated with the functional category of attention-seeking behavior. Oppositional defiant and conduct disorders were linked to the functional category of children who desire to pursue tangible reinforcement outside of school.

Reliability of clinician judgments regarding the function of children's school refusal behaviors was studied by Daleiden, Chorpita, Kollins, and Drabman (1999) using several judges who reviewed school refusal cases. The judges reviewed multiple sources of data on 20 children diagnosed with school refusal. Two factors, years of clinical experience and training in the four function model, were found to be related to the judge's ability to reliably determine whether the school refusal behavior was maintained by positive or negative reinforcement. The study underscored the need for practitioner training when using a functional model applied to school refusal behavior.

A CATEGORICAL PERSPECTIVE

The classification system outlined in the Diagnostic and Statistical Manual of Mental Disorders (4th ed.) (DSM-IV) (American Psychiatric Association, 1994) is a categorical approach based on specific criteria that describe features associated with adult and childhood psychopathology. The DSM-IV does not make a distinction between child and adult anxiety disorders. Separation anxiety disorder (SAD) is the only anxiety disorder designated as first diagnosed in childhood and adolescence. Reluctance or refusal to go to school is included in the diagnostic criteria for SAD.

Like adults, children and adolescents can be diagnosed under the anxiety disorders of panic disorder with or without agoraphobia, specific phobia, social phobia/social anxiety disorder, obsessive-compulsive disorder, post-traumatic stress disorder, and generalized anxiety disorder. Similarly, if criteria are met, children and adolescents can be diagnosed with a mood disorder such as major depressive episode or dysthymic disorder. Developmental factors relative to children are to be considered within each diagnostic category.

Children can be diagnosed with the disruptive behavior disorders of oppositional defiant disorder (ODD) and conduct disorder (CD). ODD and CD refer to children who act out and have behavioral problems. The DSM-IV defines the essential feature of ODD as "a recurrent pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures that persists for at least 6 months" (American Psychiatric Association, 1994, p. 91). The essential feature of conduct disorder is defined as "a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated" (p. 85). Truancy is one of the diagnostic criteria found under conduct disorder.

Studies that have explored diagnostic subgroups associated with school refusal behavior have found anxiety disorders to be most prevalent (Bernstein et al., 1997; Kearney & Albano, in press; Last et al., 1987; Last & Strauss, 1990). Kearney and Albano examined a group of 143 children demonstrating school refusal behavior and found SAD to be most prevalent (22.4%), followed by generalized anxiety disorder (10.5%) and oppositional defiant disorder (8.4%). Other diagnoses included major depression (4.9%), specific phobia (4.2%), and social anxiety disorder (3.5%). There was considerable comorbidity with several of the subjects receiving more than one diagnosis.

Last and Strauss (1990) analyzed a group of 63 school refusing children and adolescents referred to an anxiety disorder clinic and found the following anxiety disorder diagnoses: SAD (38.1%), social phobia (30.2%), simple phobia (22.2%), panic disorder (6.3%), and post-traumatic stress disorder (3.2%). One-quarter of the 63 children were diagnosed with comorbid overanxious disorder.

Similarly, in a sample of 64 children with school refusal behavior, Kearney (as cited in Kearney & Silverman, 1996) reported that the most frequent diagnoses were overanxious disorder (18.8%), SAD (18.8%), and avoidant disorder (7.8%). As is typical for children with school refusal, there was considerable comorbidity between anxiety disorders in this group. For example, for children diagnosed with SAD, 66.7% also met criteria for overanxious disorder. Major depression was present in 6.3% of this group of children. As was previously noted, ODD was present in 6.3% of the sample. An important finding with regard to this sample of children was that 26.6% of the children did not meet criteria for diagnosis of any disorder.

Other studies have reported similar findings. For example, Kearney and Albano (in press) found that 32.9% of their sample of 143 children received no diagnosis. Bernstein and Garfinkel (1986) found that 11.5% of their sample did not meet diagnostic criteria for any disorder. Kearney (2001) observed that children who do not meet diagnostic criteria for any mental disorder may have exhibited symptoms of various disorders associated with school refusal (e.g., anxiety, depression) that were not at clinical levels. King et al. (1995) assert that for children who do not present with a diagnosable disorder, the problem may be less child-related and more likely related to parental psychopathology or to a "systemic problem in the school itself" (p. 15).

Though prevalence rate estimates vary, several studies have revealed a link between school refusal and depression (Bernstein & Garfinkel, 1986, 1988; Last et al., 1987; Last & Strauss, 1990). Based on a review of seven studies examining diagnoses associated with school refusal, Kearney (1993) reported an estimated depression and school refusal comorbidity rate of 31.4%. In their study of 26 early adolescents with chronic school refusal, Bernstein and Garfinkel (1986) reported a strong overlap between the presence of anxiety disorders and depression. Sixty-nine percent of the adolescents met criteria for an affective disorder (major depressive episode or adjustment disorder with depressed mood). Of those individuals diagnosed with depression, 50% met criteria for both an anxiety disorder and depression. The students who scored the highest on self-report measures for anxiety and depression were considered to have more severe symptoms than those diagnosed with anxiety alone. However, the group who met criteria solely for a mood disorder did not differ in severity from the combined anxiety and depression group. Examples of severe symptoms included suicidal ideation, panic attacks, and symptoms of agoraphobia.

Due to evidence linking depression and school refusal, the possibility of the presence of depression or symptoms/characteristics of depression should not be overlooked. Primary features of depression in school-aged children are well documented: depressed mood or marked sadness, lack of interest in activities, failure to make expected weight gains, sleep difficulties, fatigue or lethargy, feelings of worthlessness/inadequacy or excessive guilt, difficulty concentrating or indecisiveness, and thoughts of death or suicidal ideation (American Psychiatric Association, 1994).

Anger, irritability, and somatic complaints are common characteristics of depression manifested in children and adolescents. Negative affectivity is prevalent and easily identified. Comments such as "School is dumb," "I hate it," and "Nobody likes me" point to an underlying negative affectivity from students who simply look sad. A most serious symptom of depression among children and adolescents is preoccupation with suicide. The presence of suicidal thoughts or plan should be considered significant and appropriate steps taken to ensure the safety of the child (see Poland & Lieberman, 2002, for a detailed discussion of best practices in suicide intervention).

PRESENTING FEATURES OF STUDENTS WITH ANXIETY-BASED SCHOOL REFUSAL

The following section describes the essential features of separation anxiety, social phobia, and generalized anxiety disorder, all found in high rates in studies of children who exhibit school refusal. Though they are presented as distinct clusters with emotional, cognitive, and behavioral features, it is often difficult to distinguish between anxiety disorders because there is so much overlap among them.

SEPARATION ANXIETY

Children with separation anxiety show excessive fear surrounding separation from major attachment figures (American Psychiatric Association, 1994; see Table 2 on page 14). They become preoccupied with thoughts of harm befalling their loved ones. These children worry about their parents getting hurt in an automobile accident, getting sick, or dying. The separation anxiety is extreme and falls outside of the boundaries of what would be considered "normal" separation reluctance found in many young children.

At home children with SAD are overly dependent, often resisting sleeping or even playing alone. In school, difficulty concentrating on school work is common, and children may frequently request to call or go home. As shown in Table 2, reluctance or refusal to go to school is one criterion for diagnosis under SAD. Close inspection of attendance records may reveal a pattern of tardiness possibly the result of before-school battles with parents. Panic-like symptoms may result in clinging or even striking out at others trying to pry a child away from a caregiver. Physical complaints are common and include stomachaches, headaches, and nausea or vomiting (American Psychiatric Association, 1994).

SOCIAL PHOBIA/PERFORMANCE ANXIETY

Children with social phobia have extreme fear surrounding social situations where the possibility of embarrassment may occur (see Table 3 on page 16). Social or performance situations create intense anxiety and avoidance responses although the situation may be "endured with dread" (American Psychiatric Association, 1994, p. 411). Public speaking, tests, or anticipating having to socialize at recess time are examples of situations that cause extreme anxiety for children with social or performance anxiety. Worrying about what others think, concern over how they will be judged, and fear of humiliation are cognitive features associated with social anxiety. An assignment to give a speech can result in severe anticipatory anxiety for students who self-consciously fear others will see their hand tremble or hear their voice shake. Social anxiety can manifest itself as dread and avoidance of the school locker room or refusal to participate in sports because of a fear of humiliation. The resulting restriction and avoidance of activities and peers causes many of

TABLE 2

DIAGNOSTIC CRITERIA FOR SEPARATION ANXIETY DISORDER

A. Developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached, as evidenced by three (or more) of the following:

   1. recurrent excessive distress when separation from home or major attachment figures occurs or is anticipated
   2. persistent and excessive worry about losing, or about possible harm befalling, major attachment figures
   3. persistent and excessive worry that an untoward event will lead to separation from a major attachment figure (e.g., getting lost or being kidnapped)
   4. persistent reluctance or refusal to go to school or elsewhere because of fear of separation
   5. persistently and excessively fearful or reluctant to be alone or without major attachment figures at home or without significant adults in other settings
   6. persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home
   7. repeated nightmares involving the theme of separation
   8. repeated complaints of physical symptoms (such as headaches, stomachaches, nausea, or vomiting) when separation from major attachment figures occurs or is anticipated

B. The duration of the disturbance is at least 4 weeks.

C. The onset is before age 18 years.

D. The disturbance causes clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.

E. The disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and, in adolescents and adults, is not better accounted for by Panic Disorder With Agoraphobia.

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these children to be lonely and to have few friends (Beidel, Turner, & Morris, 1999). Like separation anxiety, severe social or performance anxiety may result in panic-like symptoms or panic attacks (American Psychiatric Association, 1994).

Kearney and Beasley (1994) surveyed 63 professional psychologists in children and family practice. The psychologists reported that half of the children they treated for school refusal stayed home in order to avoid aversive social situations such as tests, giving speeches, the curriculum and homework, interacting socially with others, and athletic performance.

GENERALIZED ANXIETY DISORDER

For children diagnosed with generalized anxiety disorder, worry and anxiety are excessive, difficult to control, and significant enough to interfere with school performance (American Psychiatric Association, 1994) (see Table 4 on page 17). For these children, the world is perceived as threatening. There may be a vague sense that something bad is going to happen or worries about specific events such as tornadoes or war. Perfectionism is a characteristic of children with generalized anxiety disorder. They may frequently re-do assignments, starting over so many times that homework time becomes excruciating for both child and parent. Because of a sense of inadequacy and uncertainty, children with generalized anxiety disorder seek frequent reassurance from parents, teachers, and other adults regarding their performance. They are often concerned about pleasing others and may tend to try to hide their distress from teachers and peers (Kendall, Chansky, et al., 1992). Additional features include fatigue, restlessness, difficulty concentrating, irritability, sleep disturbance, and muscle tension (American Psychiatric Association, 1994).

SOMATIC COMPLAINTS AND SCHOOL REFUSAL BEHAVIOR

Children presenting with school refusal behavior have high rates of somatic complaints. As was previously noted, in a survey of 288 elementary and secondary school principals, Stickney and Miltenberger (1998) found an overall rate of 2.3% of students identified as school refusers. Somatic complaints without the presence of a medical condition were reported present in 49% of the school refusers with 30% demonstrating somatic complaints with an accompanying medical condition.

It can be difficult to determine when children who refuse school are truly sick. Teachers and school nurses, however, become adept at knowing who is a "regular," that is, a student who visits the nurse's office on a regular basis with physical complaints (headaches, stomachaches, or a hurt finger). A more complicated scenario occurs when a student's legitimate medical concern (e.g., asthma) contributes to a pattern of school refusal. Here, a

TABLE 3

DIAGNOSTIC CRITERIA FOR SOCIAL PHOBIA

A. A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing. Note: In children, there must be evidence of the capacity for age-appropriate social relationships with familiar people and the anxiety must occur in peer settings, not just in interactions with adults.

B. Exposure to the feared social situation almost invariably provokes anxiety, which may may take the form of a situationally bound or situationally predisposed Panic Attack. Note: In children, the anxiety may be expressed by crying, tantrums, freezing, or shrinking from social situations with unfamiliar people.

C. The person recognizes that the fear is excessive or unreasonable. Note: In children, this feature may be absent.

D. The feared social or performance situations are avoided or else are endured with intense anxiety or distress.

E. The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.

F. In individuals under age 18 years, the duration is a least 6 months.

G. The fear or avoidance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition and is not better accounted for by another mental disorder (e.g., Panic Disorder With or Without Agoraphobia, Separation Anxiety Disorder, Body Dysmorphic Disorder, a Pervasive Developmental Disorder, or Schizoid Personality Disorder).

H. If a general medical condition or another mental disorder is present, the fear in Criterion A is unrelated to it, e.g., the fear is not of Stuttering, trembling in Parkinson's disease, or exhibiting abnormal eating behavior in Anorexia Nervosa or Bulimia Nervosa.

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TABLE 4

DIAGNOSTIC CRITERIA FOR GENERALIZED ANXIETY DISORDER

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The person finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months). Note: Only one item is required in children.

1. restlessness or feeling keyed up or on edge
2. being easily fatigued
3. difficulty concentrating or mind going blank
4. irritability
5. muscle tension
6. sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)

D. The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g., the anxiety or worry is not about having a Panic Attack (as in Panic Disorder), being embarrassed in public (as in Social Phobia), being contaminated (as in Obsessive-Compulsive Disorder), being away from home or close relatives (as in Separation Anxiety Disorder), gaining weight (as in Anorexia Nervosa), having multiple physical complaints (as in Somatization Disorder), or having a serious illness (as in Hypochondriasis), and the anxiety and worry do not occur exclusively during Posttraumatic Stress Disorder.

E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

F. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder.

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child's asthma may be an initial legitimate reason for school absence. Later, anxiety about returning to school serves to maintain the school avoidance even after the child recovers physically. School personnel should consult with the child's physician to determine if a medical condition such as asthma would preclude return to school (King et al., 1995) or result in restrictions on activity while in school.

Certainly, there are times when a child clearly has a legitimate medical concern that necessitates extended absence from school. A child's absenteeism as a result of a legitimate medical illness is not considered school refusal.

A DIMENSIONAL PERSPECTIVE: INTERNALIZING VERSUS EXTERNALIZING BEHAVIORS

Empirically based classification systems use factor analysis to identify clusters of emotional or behavioral characteristics in children and adolescents. A widely used empirically based classification system is the Achenbach System of Empirically Based Assessment (Achenbach, 1991a, 1991b; Achenbach & Rescorla, 2001). Two components of the system, the Child Behavior Checklist (CBCL) and the Teacher Report Form (TRF), are behavior rating scales used to obtain parent and teacher perspectives of a child's behavior.

The internalizing and externalizing scales of the CBCL and TRF reflect a distinction between fearful, over-controlled, inhibited behavior, and aggressive, antisocial, under-controlled behavior. The scales are further broken down into the following eight syndromes: Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Social Problems, Thought Problems, Attention Problems, Rule-Breaking Behavior, and Aggressive Behavior.

The internalizing grouping of the newly revised CBCL (Achenbach & Rescorla, 2001) is composed of three of the syndromes, Anxious/Depressed, Withdrawn/Depressed, and Somatic Complaints. Internalizing behavior refers to anxiety, depression, somatic complaints, and withdrawal. Two scales, Rule-Breaking Behavior and Aggressive Behavior, comprise the externalizing grouping that refer to acting out behavior manifested as conflicts with other people (Achenbach & Rescorla, 2001).

Although there is not a school refusal syndrome as such, the item "fears going to school" is included under the Anxious/Depressed syndrome on the internalizing dimension. The item, "truancy, skips school" falls under the Rule-Breaking Behavior syndrome on the externalizing dimension. Though there are children who have primarily internalizing or, conversely, primarily externalizing problems, the dimensions are not mutually exclusive especially for children with significant pathology (Achenbach & Rescorla, 2001). Children who have *significantly high* scores on one dimension tend to score at *least* above average on the other (Achenbach, 1991a; Achenbach & Rescorla, 2001).

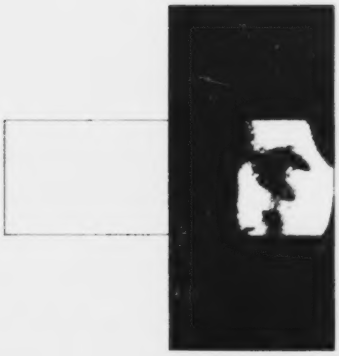
Likewise, analysis of the CBCL and TRF by researchers interested in school refusal behavior has revealed that the scales may not discriminate among subtypes of school refusers because of the extreme diversity among them (Kearney & Silverman, 1996). Nonetheless, when implemented as part of a multidimensional assessment, analysis of the constructs of internalizing and externalizing behavior can be useful in diagnostic decision making and intervention planning for children with school refusal behaviors.

SUMMARY

There is no single cause for school refusal. Children who exhibit school refusal are a heterogeneous group who differ in level of severity and motivation for their behavior. Among children who refuse school for emotional reasons, anxiety disorders are most prevalent. School refusal is prevalent in approximately 2% of school-age children though some estimates are as high as 5%.

The number of terms applied to school refusal and associated constructs is confusing for those seeking to understand and intervene effectively. School refusal refers to primarily emotionally based absenteeism initiated by the child and includes children who exhibit anxiety disorders such as separation anxiety, social phobia, as well as co-occurring depression. The term, "school refusal behavior," encompasses both emotionally driven school refusal and the behaviors associated with truancy.

Classification systems have typically assigned subtypes using functional, categorical, and dimensional perspectives. A functional approach toward classification identifies motivating variables for the school refusal behavior. Most school psychologists are well versed in the use of functional behavioral assessment. Therefore, applying a functional approach toward understanding school refusal behavior would appear to be particularly applicable for those working in school settings.



CHAPTER 2

HISTORY AND ETIOLOGY OF SCHOOL REFUSAL

Broadwin (1932) is credited with being the first to write about anxiety-related school attendance problems. His psychoanalytically oriented interpretation viewed the anxiety experienced by the child as "a deep-seated neurosis of the obsessional type" (p. 254). According to Broadwin, obsessions about something "terrible" happening to the child's mother resulted in a desire to "run home to be assured that nothing has happened to her" (p. 254). In 1939, Partridge used the term "psychoneurotic truancy" to refer to anxious children whose difficulty separating from an overprotective parent resulted in tantrums, guilt, and the need for attention.

Johnson et al. (1941) formulated a psychodynamically oriented theory that linked school absenteeism to a history of a poorly resolved dependency relationship between the mother and child. Johnson is credited with being the first to use the term "school phobia," and his (Johnson, 1957) view of the primary etiology of school phobia as separation anxiety dominated the conceptualization of school refusal for years and was primarily based on case study and anecdotal reports.

Psychodynamic treatment was insight-oriented, with the focus either individually on the child or mother-child relationship (Blagg, 1987). Glaser's (1959) psychodynamic approach emphasized immediate return to school. Other descriptions of psychodynamic treatment include family and inpatient approaches though treatment was generally out-patient or community-based (see Blagg, 1987).

BEHAVIORAL PERSPECTIVES

Behavioral conceptualizations of school refusal gained impetus in the 1960s and 1970s. From a learning theory perspective, separation anxiety is learned. It is developed and maintained through principles of operant and classical conditioning. Garvey and Hegrenes (1966) used classical conditioning to explain the development of school phobia for a 10-year-old boy who refused to go to school. The authors theorized that the boy's fear of losing his mother became paired with a neutral stimulus (school). In a classical conditioning paradigm, school eventually became a conditioned stimulus associated with the boy's fear of losing his mother. A counter-conditioning procedure was implemented that called for pairing the feared stimulus (school) with the presence of a supportive person (the therapist) in a graduated approach to school re-entry. Sitting in the car in front of school was initiated as the first step in a 12-step desensitization hierarchy that gradually culminated with participation in class. Positive reinforcement was used in the form of praise from the therapist. The authors reported that following treatment, the boy returned to school and attended school during a two year follow-up.

Lazarus, Davison, and Polefka (1965) also presented a treatment model for school phobia based on the tenets of classical and operant conditioning. Paul, a nine-year-old student absent from school for three weeks, was treated with the use of gradual in vivo exposure, emotive imagery to reduce anxiety, and rewards contingent on school attendance. In an often-cited study, Kennedy (1965) reported complete remission of acute school phobia symptoms for 50 children following implementation of a treatment program based on behavioral principles. The rapid treatment program utilized forced school attendance (in vivo flooding), avoiding emphasis on somatic complaints, interviews with parents and children, and prevention of "secondary gains" (p. 286). A common form of secondary gain for school refusers was described by Yates (1970), who theorized that a child's anxiety about leaving his or her mother may be reinforced by the parents providing an environment more reinforcing than school.

Some researchers have applied Rachman's (1977) theory of fear acquisition to the development of school refusal behavior (King et al., 1995; Ollendick & King, 1991). Citing Rachman's theory, King et al. (1995) outlined the following pathways in which a child could potentially develop a fear of going to school: "direct conditioning (e.g., child developing a fear of school after being assaulted by peers at school), vicarious conditioning (e.g., child imitating the school-related fears of a sibling), and transmission of fear messages (e.g., child showing a fear of school as a result of hearing negative accounts of school from parents)" (p. 17).

COGNITIVE-BEHAVIORAL PERSPECTIVES

In the 1980s, identifying and modifying negative cognitions became a focus for cognitive-behavioral theorists and practitioners working with anxious and depressed youth. Early cognitive-behavioral theorists drew on adult conceptual models (Beck, 1976; Ellis, 1962; Meichenbaum, 1985). For example, the cognitive model put forth by Beck (1976) and Beck, Rush, Shaw, and Emery (1979) posits that anxious and/or depressed adults magnify and distort events and underestimate their ability to cope.

Clearly, ability to engage in abstract thinking is more limited in children, but there is evidence that anxious children can and do engage in negative cognitive activity. Kendall and Ingram (1987) describe the cognitive activity typical of anxious children as a form of self-focused attention. Similar to the adult model, this self-focused attention is characterized by misperceptions of the demands of the environment including self-criticism and under-appraisal of personal abilities (Kendall, Howard, & Epps, 1988).

Negative self-statements were found by Treadwell and Kendall (1996) to be related to degree of anxiety experienced by children diagnosed with anxiety disorders. Negative self-evaluation and anticipation of negative outcomes when presented with social-evaluative situations was found in higher rates in children with social phobia compared to nonanxious children (Spence, Donovan, & Brechman-Toussaint, 1999). Anxiety-provoking self-talk frequently initiates avoidance on the part of the individual that is then reinforced as the anxiety is subsequently reduced.

Cognitive restructuring of anxious self-talk was targeted by Mansdorf and Lukens (1987) who used a psychodynamically oriented cognitive approach in addition to behavioral techniques with two children ages 10 and 12 who had been absent from school for six consecutive weeks. After analyzing self-statements, the children were taught coping self-statements. The intervention also included cognitive restructuring with the parents by challenging their distorted beliefs regarding their children.

Typically, cognitive-behavior therapy for childhood anxiety is composed of multiple treatment packages that apply a coping skills model that incorporates the following cognitive and behavioral strategies: self-instructional techniques, in vivo exposure, imagery, relaxation, and contingent reward (Kendall, 1994). The effectiveness of cognitive-behavior therapy for treating childhood anxiety has been demonstrated in controlled studies and has been supported by favorable long-term follow-up data (Barrett, Dadds, & Rapee, 1996; Kendall, 1994; Kendall et al., 1997; Kendall & Southam-Gerow, 1996).

The effectiveness of cognitive-behavior therapy applied to school refusal behavior has been investigated in recent controlled studies (Bernstein et al., 2000; Kearney & Silverman, 1999; King et al., 1998; Last et al., 1998). Due to the multifaceted etiology of school refusal behavior, some researchers have investigated a prescriptive approach employing cognitive and behavioral techniques for treatment linked to the functional nature of the presenting problems (Kearney & Silverman, 1990, 1999). For example, recommended interventions for a child who refuses school to avoid social embarrassment would be the development of a hierarchy of anxiety-provoking performance situations, cognitive restructuring, and gradual exposure (Kearney, 2001).

GENDER AND AGE

Generally speaking, there have been no significant differences found between school refusal rates with regard to gender (Bernstein & Garfinkel, 1986; Granell de Aldaz et al., 1984; Kearney, 2001; Kennedy, 1965). Age-related trends cluster around major changes in children's lives such as entrance to kindergarten and the transition from elementary to middle school (Ollendick & Mayer, 1984) with an average age being early adolescence (Kearney, 2001). Older children tend to exhibit more severe problems and increased difficulty returning to school as compared to younger children (Last et al., 1998).

SIGNIFICANT EVENTS

Significant events may trigger school refusal in some children. Common examples are a prolonged illness, a move, changing schools, or the death of a parent (Blagg, 1987; Hersov, 1960; King, Tonge, Heyne, & Ollendick, 2000). In addition, school refusal occurs more frequently at the beginning and end of the school year (Kearney & Beasley, 1994) as well as after vacations or weekends (Blagg & Yule, 1984; King et al., 2000; Last et al., 1998).

CHILD VARIABLES

King et al. (2000) observed that children who refuse school often lack faith in their ability to cope with stressors. There is speculation that there exists an inborn vulnerability such as a behaviorally inhibited temperament that puts some children at greater risk for emotional problems including school refusal (King et al., 1995). Not surprisingly, increased dependency on parents has been linked to school refusal behavior (Berg & McGuire, 1971; Berg et al., 1969). And, as was previously noted, anxiety disorders and depression have been identified in children with school refusal (e.g., Agras, 1959; Bernstein & Garfinkel, 1986; Bernstein et al., 1997; Kearney, 1993; Kearney & Albano, in press; Last et al., 1987; Last & Strauss, 1990).

More specific child characteristics such as intelligence, learning disabilities, and academic problems have been studied in groups of children exhibiting school refusal. Hampe, Miller, Barrett, and Noble (1973) found intelligence in school phobics to mirror the general population. Kearney (2001) notes that children who refuse school generally have adequate academic skill levels and do not show an increase in learning problems. However, one study by Naylor, Staskowski, Kenney, and King (1994) examined a group of 27 hospitalized, primarily depressed school refusing adolescents for the presence of language and learning disorders. They found that the school refusers had a significantly higher incidence of learning disabilities and language impairments compared to a matched, psychiatric control group.

FAMILY VARIABLES

Researchers investigating family factors and school refusal have found high rates of anxiety and depressive disorders among the parents of these children (Bernstein & Garfinkel, 1988; Martin et al., 1999). High rates of anxiety and depression were found in first-degree relatives of six children with severe school phobia plus depression and anxiety (Bernstein & Garfinkel, 1988). Martin et al. (1999) found a high prevalence rate of depressive and anxiety disorders in mothers and fathers in a sample of 51 children diagnosed with anxiety-based school refusal.

Often parents of children with school refusal do not parent as a team and demonstrate ineffective parenting skills (King et al., 2000). Significant family dysfunction with regard to role performance, values, and norms was found in a study of 76 families of children with school phobia (Bernstein, Svingen, & Garfinkel, 1990). The authors observed that in families where role performance is poorly defined the child becomes controlling and parents are ineffective in getting their child to return to school. There was less family dysfunction among the families in this study when the child was diagnosed with an anxiety disorder only in the absence of other comorbid disorders. Rates of reported family dysfunction increased in children diagnosed with conduct and oppositional disorders.

Kearney and Silverman (1995) analyzed the following family subtypes found in families of children with school refusal behaviors:

- Enmeshed parent-child dyads, characterized by dependency and over-indulgence
- Conflictive families, characterized by high rates of coercion, noncompliance, and aggression
- Detached families, characterized by diffusion of activity and little intrafamilial interaction

- Isolated families, characterized by little extrafamilial contact
- Healthy families with a child with individualized psychopathology (p. 60)

There is often overlap among subtypes.

Financial stressors such as when one or both parents lose their job can contribute to a pattern of school refusal behavior. Another highly stressful and disruptive situation for families is homelessness, which is associated with high rates of absenteeism (Rafferty & Shinn, 1991).

SCHOOL VARIABLES

Ian hides under the bed on Sunday evenings to protest going to school. He was once a child who loved school, but he began to be picked on and called names in fourth grade and now in fifth he says he hates school. Name calling at recess and during the walk home from school escalated to physical aggression toward him. He began to have nightmares, night terrors, and stomachaches along with morning and evening complaints about not wanting to go to school the next day. The bullying problem was reduced with the help of the principal and teachers. Counseling on strategies to cope with the bullies and intervention from the principal and teachers to help stop it helped reduce Ian's school refusal behaviors.

School climate issues can contribute to school absenteeism. Motivation for school avoidance can include feeling unsafe at school as in when a child is bullied, feels other students do not like him or her, or feels left out (Taylor & Adelman, 1990). School factors that have been identified as contributing to school refusal behavior are: (a) generally high absenteeism rates for students and staff, (b) large groups of low achieving older students, (c) large class sizes, (d) a high level of disruptiveness and discipline problems and associated low staff morale, (e) an authoritarian style of school management, (f) staff members unwilling to accommodate the individual needs of children, and (g) staff members anxious and dependent on children for approval (Blagg, 1987; Hersov, 1985; King et al., 1995). Other school factors include staff-student interaction styles and too much emphasis on competition or testing (Pilkington & Piersel, 1991).

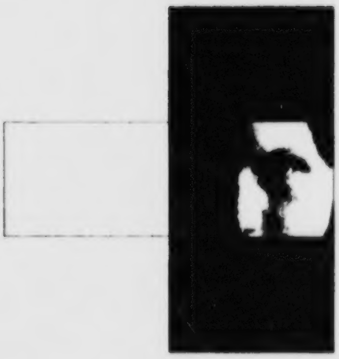
CONSEQUENCES OF SCHOOL REFUSAL BEHAVIOR

Several follow-up studies show that many youth previously treated for school refusal have consistent school attendance after treatment (Berg, 1970; King et al., 1998; Last et al., 1998; Timberlake, 1984). Research, however, indicates that there are significant consequences associated with school refusal and, for a percentage of individuals, poor long-term prognosis. Short-term consequences may include reduced academic performance, interference with social development, and significant stress on the child and family (King et al., 1995). When a child misses school there is a high probability that grades will be lowered. In severe cases when a child is absent for extended periods, school staff may feel compelled to retain despite little evidence to suggest that retention is an effective intervention to ameliorate poor academic achievement (see Rafoth, 2002).

School refusal has been associated with social impairment and higher than expected rates of affective disorders later in life (Berg & Jackson, 1985) as well as with increased rates of outpatient psychiatric treatment (Flakierska et al., 1988). Individuals who have high rates of absenteeism in elementary grades are at risk for dropping out of school, putting them at risk for joblessness and poverty (Kortering et al., 1997).

SUMMARY

Historically, psychodynamically oriented theories focusing on separation anxiety and dysfunctional mother-child relationships dominated the literature in the mid part of the twentieth century. Behavioral theorists began applying behavioral principles and learning theory to the problem in the 1960s and 1970s. Research has been accumulating on cognitive-behavioral approaches to school refusal behavior in the past two decades. An emerging area of research focuses on prescriptive approaches that link intervention to specific functions or causes of the school refusal behavior. Events such as changing schools can trigger school refusal in some children. Specific factors such as academic problems and intelligence generally have not been found to discriminate school refusers from the general population. There may be family or school factors contributing to and possibly reinforcing the behaviors. Finally, it is widely agreed that there is a need to effectively address the problem of school refusal given the serious short- and long-term consequences associated with it.



CHAPTER 3

IDENTIFICATION AND ASSESSMENT OF SCHOOL REFUSAL

"Every science and every inquiry, and similarly every activity and pursuit, is thought to aim at some good."

—Aristotle, Nicomachean Ethics

A sixth-grade teacher approaches you about a student who has missed school on and off for months and now, alarmingly, has been absent for two consecutive weeks. A high school junior and national honor society member stops coming to school and reportedly does not want to leave the house. It is October, and on Monday mornings you can hear the cries of a first grader who panics at leaving his mother to come to school.

These hypothetical scenarios are situations typically presented to school psychologists by worried teachers and parents. School psychologists can and should take an active role in helping to solve these difficult dilemmas.

Initial screening of severity may reveal a temporary problem such as a kindergartner's separation anxiety at the beginning of the school year. Problems that are self-corrective may require little or no intervention and consequently may not require formal assessment. Alternately, school refusal behavior may be a symptom of emotional, behavioral, or learning problems including severe anxiety or panic disorder, depression or suicidal behavior,

behavior disorders, general defiance, lack of motivation, or learning disabilities (Elliott & Place, 1998; Kearney, 2001). Accordingly, general emotional and behavioral functioning should be assessed and features associated with the behavior identified (e.g., anxiety or depression). Consideration also needs to be given to medical, school, or family variables which may influence the school refusal behavior (see Table 5 on page 31).

MULTIDIMENSIONAL ASSESSMENT

There has been a growing accumulation of literature on the topic of assessment of school refusal behavior. Researchers recommend generating hypotheses regarding etiology and function of school refusal behavior through multidimensional assessment implementing interviews, observation, behavior rating scales, and self-report measures (e.g., Elliott, 1999; Elliott & Place, 1998; Kearney, 2001; King et al., 1995; Lee & Miltenberger, 1996). Additionally, functional assessment procedures are used to generate hypotheses about the cause of the behavior to help determine what intervention is most appropriate (Kearney, 2001; Kearney & Albano, 2000; Kearney & Silverman, 1990, 1996, 1999). As with all child behavioral assessment, assessing school refusal is a fluid exercise in hypothesis testing using a range of procedures that are developmentally appropriate and psychometrically reliable and valid (King et al., 1995; Mash & Terdal, 1981; Ollendick & Hersen, 1984; Ollendick & King, 1999).

The rationale for using multidimensional assessment rather than relying on a single method or source of information is to reduce bias and develop a full and accurate picture of the problem (Elliott & Place, 1998; Kearney, 2001; King et al., 1995). For example, a teacher may not be aware of a child's anxiety related to participating in class and the child may not feel comfortable sharing his or her distress. However, a parent interview, observation of the child, or self-report measure could potentially uncover the presence of severe performance anxiety surrounding speaking in class.

Kearney and Silverman (1990, 1999) and King et al. (1995) recommend a functional assessment of antecedents and consequences to the behavior. Following assessment, prescriptive interventions are selected based on the function of the child's behavior. To date there are little data on the use of functional behavioral assessment for school refusal by school personnel in educational settings. There is preliminary support for the use of functional behavioral assessment as a guide for planning interventions for school refusal behaviors in clinical, research settings (Chorpita, Albano, Heimberg, & Barlow, 1996; Kearney & Silverman, 1990, 1999).

A collaborative team approach has been recommended for school-based assessment and intervention planning for school refusal referrals (Paige, 1993; Want, 1983). A logical

TABLE 5

CONTRIBUTING VARIABLES TO SCHOOL REFUSAL BEHAVIOR

Medical

- Chronic illness
- Student recently hospitalized or kept home due to prolonged illness

School

- Child wants to avoid performance situations (e.g., tests, giving a speech, physical education class)
- Child feels unsafe at school (e.g. bullied, threatened, fears physical violence)
- Child feels left out, teased
- Academic difficulties
- Teacher interactions with the student are overly negative

Family

- Family member suffering from anxiety, depression, or other emotional disorder
- Significant family dysfunction present
- Ineffective or lack of parenting
- Significant financial stressors

Life Events

- Major life changes (e.g. move, parent's divorce, change of schools)
- Child experienced or witnessed a traumatic event

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process for accomplishing this task is within the context of problem-solving or school intervention teams. Problem-solving consultation is a collaborative team approach to providing school psychological services, which has been forwarded as a best practice model for assessment and intervention of academic and behavior problems (Reschly & Ysseldyke, 2002). Approaching the problem as a team endeavor is particularly important with school refusal referrals given their multifaceted and sometimes intransigent nature that can be challenging even for the most experienced school psychologist.

Problem-solving teams implement data-based decision making through a process of identification and assessment of the problem, followed by data analysis and intervention planning. Finally, interventions are implemented and monitored for effectiveness (Bergan & Kratochwill, 1990; Callan-Stoiber & Kratochwill, 2002; Kratochwill, Elliott, & Callan-Stoiber, 2002; Tilly, 2002). Problem-solving procedures have been applied to school refusal referrals in school settings as outlined in the decision matrix found in Figure 1 on page 33 (Paige, 1993).

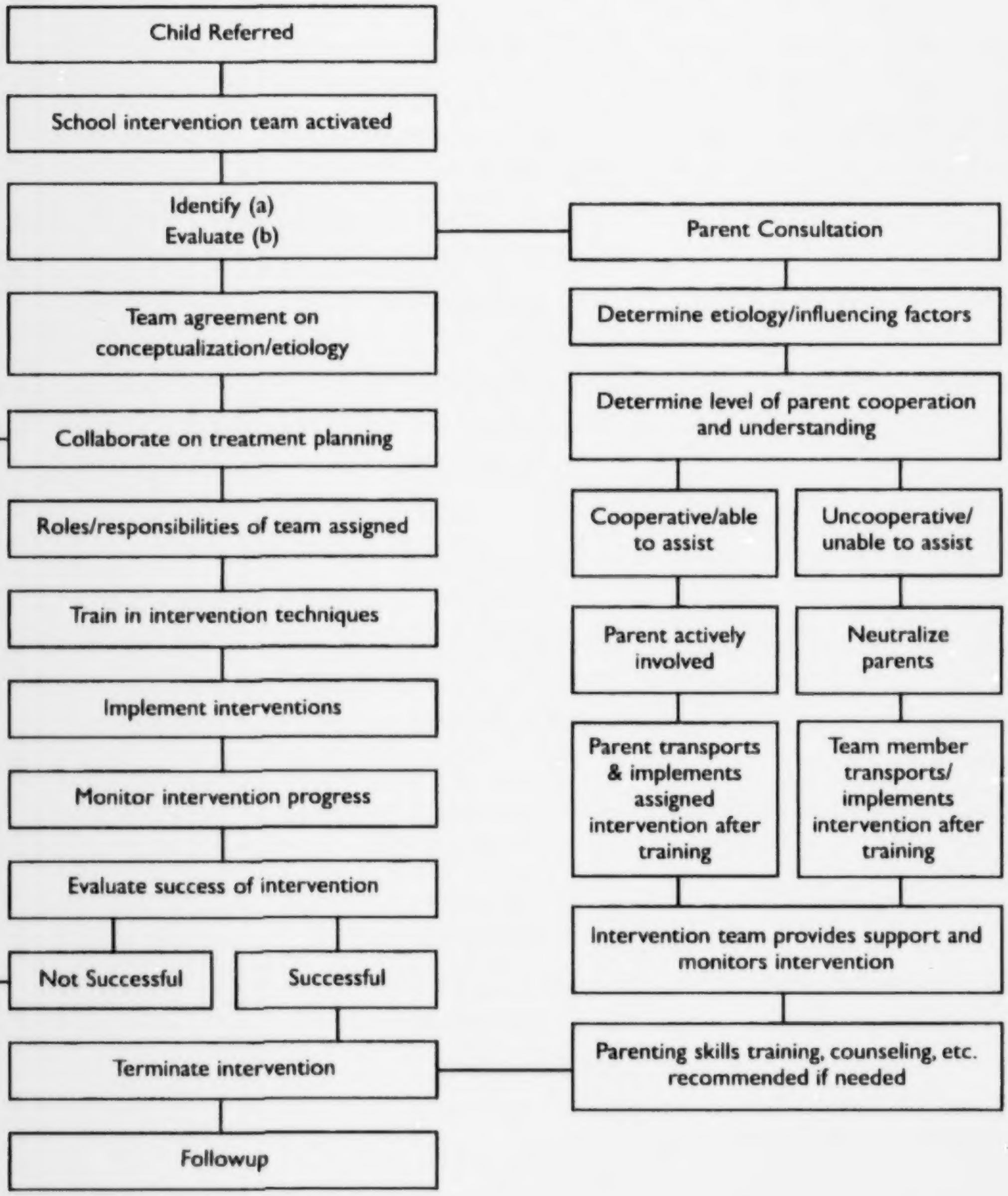
The problem-solving team for school refusal referrals may include any combination of the following school staff members: school psychologist, principal, teacher, guidance counselor, social worker, school nurse, school attendance or liaison officer, and parents (Paige, 1993). Teams may also include community-based therapists, social service case workers, physicians, or the child particularly if the student is older (Paige, 1997). An important consideration will be to assess the need for referral to community-based mental health providers.

For children who are not attending school at all, working with clinic-based therapists to collaborate on plans for re-entry will be particularly important. School psychologists, by virtue of training and expertise, are well suited to coordinate school, family, and community-based professionals and to coordinate intervention within the school (Blagg, 1987; Elliott & Place, 1998; Paige, 1997). It is widely recognized that collaboration between professionals is crucial to the success of treatment of school refusal behaviors (King et al., 1995; King et al., 1998; Paige, 1993).

The assessment component of problem-solving consultation is inextricably linked to intervention (Reschly & Ysseldyke, 2002). Accordingly, the purpose of assessment of school refusal behaviors within a problem-solving paradigm is to develop effective interventions geared toward increasing the child or adolescent's ability to meet the developmental demands of consistent school attendance. The multidimensional assessment measures outlined below can be used to guide this process.

FIGURE 1

PROCEDURE DECISION MATRIX FOR SCHOOL REFUSAL


Child Referred
School intervention team activated
Identify (a)
Evaluate (b)
Team agreement on conceptualization/etiology
Collaborate on treatment planning
Roles/responsibilities of team assigned
Train in intervention techniques
Implement interventions
Monitor intervention progress
Evaluate success of intervention
Not Successful
Successful
Terminate intervention
Followup
Parent Consultation
Determine etiology/influencing factors
Determine level of parent cooperation and understanding
Cooperative/able to assist
Uncooperative/ unable to assist
Parent actively involved
Neutralize parents
Parent transports & implements assigned intervention after training
Team member transports/ implements intervention after training
Intervention team provides support and monitors intervention
Parenting skills training, counseling, etc. recommended if needed

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ATTENDANCE HISTORY, MEDICAL FACTORS, AND SCHOOL RECORD REVIEW

An important initial step in the assessment process is to consult attendance records to determine how often the student has been absent or tardy. Typically, the school attendance officer or school secretary can provide a printed copy of the student's attendance record. A determination should be made whether the school makes follow-up telephone calls to parents or guardians regarding unexcused absences. (Sometimes, just a phone call urging the parent to bring the child to school can be the difference between a child being tardy or missing an entire day of school.)

As was discussed in Chapter 1, a determination needs to be made if there is a legitimate medical reason for the absence. Physical conditions that may present themselves in cases of school refusal, include asthma, pain, or ulcers (Kearney, 2001). Ongoing consultation with the child's physician is recommended if there is a medical reason for, or contributing to, the absences (Elliott & Place, 1998; Kearney & Albano, 2000; King et al., 1995).

A review of the student's cumulative file will reveal if there is a history of absenteeism and should provide information relative to previous efforts to ameliorate the problem. Record review of report cards and group achievement test scores provides current and previous levels of academic functioning. An examination of academic achievement levels will help determine whether the child's performance is consistent with grade level expectations or if academic difficulties are potentially contributing to the school refusal behavior. (When academic difficulties are suspected, curriculum-based and/or formal achievement testing may be needed.) Additionally, records will reveal if there is a pattern of frequent changes in schools, serious medical issues, or previous school psychological or special education evaluations.

Conducting a thorough assessment is a difficult undertaking if the student is not attending school at all. In such cases, school staff may need to rely primarily on interview with parents and teachers, record review, and/or rating scales. A visit to the home to observe the child's morning routine or to interview the child or adolescent may be appropriate in some situations. As with all referrals, informed parental consent for evaluation should be obtained prior to meeting with the child.

INTERVIEWS

The interview process is an important opportunity to establish rapport and gain the trust of the student, family members, and/or teacher. During the parent interview, information relative to developmental, medical, school, and attendance history is reviewed in detail. Parents are asked to describe their primary concerns regarding their child. The school refusal behavior is operationally defined in terms of specific behaviors present. It is important to determine how often, with whom, and under what conditions the behavior occurs.

King et al. (1995) recommend the use of problem-focused behavioral interviews to elicit detailed information regarding behaviors and feelings surrounding the school refusal. Problem-focused interviews define behaviors associated with the problem and their severity and contribute to an understanding of the functions or reasons for the child's school refusal behavior (Kearney, 2001; Kearney & Albano, 2000). The interviewer asks parents and/or teachers questions about possible antecedents and consequences to the school refusal behavior. Questions should be fairly specific such as, "Is the child ever distressed about giving speeches or taking tests?" or "How comfortable is the child in social situations with teachers and peers?" or "What activities is the child engaged in when at home during a school day?" For interviews with children, King et al. (1995) suggest asking specific questions such as, "'What exactly makes you afraid in school?'" (p. 33). It is important to ask children about their primary concerns and their thoughts and feelings surrounding the school refusal behaviors.

Structured interview formats such as the Anxiety Disorders Interview Schedule for Children-Child and Parent Versions (ADIS-C/P; Silverman & Albano, 1996; Silverman & Nelles, 1988) are frequently used to contribute to DSM-IV diagnostic decision making in clinical, research settings. Broad-based semistructured parent interviews such as the Structured Developmental History of the Behavior Assessment System for Children (BASC; Reynolds & Kamphaus, 1992) cover in depth information relative to social, developmental, educational, and medical factors. Sattler (2002) offers semistructured interview formats for a wide range of referral scenarios including interview questions for children, parents, and teachers that can be used for school refusal referrals.

OBSERVATION

Direct observation contributes to an understanding of probable environmental influences to school refusal behaviors. How quickly does a child's tantrum behavior dissipate after a parent leaves? What behaviors on the part of caregivers or teachers contribute to a reduction in the tantrum behavior? Observations can help define the problem particularly if there is conflicting data collected from other sources such as interviews or self-report measures. Direct observation can be implemented as a narrative recording using a simple running log of events, or using an A-B-C (antecedent, behavior, consequence) format. Alternately, empirically based systems are useful when evaluators are interested in obtaining a quantitative analysis of behavior (e.g., event or duration recording).

Narrative recording: A functionally based narrative recording approach utilizes an A-B-C chart to keep a running log of antecedents, behaviors, and consequences. For example, a team may be interested in determining predictors and consequences of behaviors associated with a student's separation or social anxiety. Specific events that serve to trigger the behavior are recorded, followed by a description of the behaviors and their consequences.

Empirically based systems: Event and duration recording are examples of empirically based observation recording procedures. These procedures are most appropriate for behaviors that have clearly defined beginning and ending points (e.g., tantrums). Event recording is a count of how many times a behavior occurs within a specified time frame. For example, a daily frequency count of the number of tantrums associated with school attendance. The target behavior, tantrums, would be first operationally defined as crying, whining, and/or running away (King et al., 1995). The duration of the tantrum would be recorded for a baseline measure of severity.

Teams may be interested in both event and duration recordings of behavior prior to, during, and following intervention. For example, an analysis of whether the number of tantrums related to school refusal decrease as the week progresses (event recording) or if there is a decrease in length of the tantrums following intervention (duration recording). Several empirically based behavior recording systems are available that provide observation forms for functional assessment of problem behaviors and can be used for observation of school refusal behaviors (e.g., O'Neill et al., 1997).

PARENT AND TEACHER RATINGS

Parent and teacher rating scales are helpful especially when the problem appears to be severe or chronic and a more comprehensive assessment of the child's behavior is required. Parent and teacher ratings provide a description of children's behavior at home and school from the perspective of informants who know the child well. At times, however, the perceptions of raters may conflict with information gathered from other sources (King et al., 1995) underscoring the need for cross-referencing with data from interviews, observations, and self-report measures. As with all child behavioral assessment measures, users should consult test manuals and secondary sources for information relative to reliability and validity (e.g., Sattler, 2002).

The Child Behavior Checklist (CBCL; Achenbach 1991a; Achenbach & Rescorla, 2001) and Teacher's Report Form (TRF; Achenbach, 1991b; Achenbach & Rescorla, 2001) are designed to assess internalizing and externalizing behaviors in children and adolescents ages 6–18 years (a preschool version is also available). Parents and teachers answer a series of questions on a 0-2–point scale (not true, somewhat or sometimes true, and very true or often true). As was outlined in Chapter 1, the CBCL and TRF are composed of eight syndrome scales and six DSM-IV–oriented scales.

SELF-REPORT MEASURES

Self-report measures can provide insights into thoughts and feelings that may contribute to school refusal behaviors and valuable information relative to signs and symptoms of anxiety and depression and their severity as reported by the child. The following self-report measures are useful for assessing anxiety and depression in children and adolescents.

The Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1985) is a 37-item self-report measure used to assess the severity and nature of anxiety in children and adolescents ages 6–19 years. The RCMAS consists of three scales: Physiological Anxiety, Worry/Oversensitivity, and Social Concerns/Concentration. The RCMAS yields a Total Anxiety and Lie Scale score. Respondents answer yes or no to questions relative to specific as well as global anxiety or worry.

The Children's Depression Inventory (CDI; Kovacs, 1992) is a 27-item self-report questionnaire for children and adolescents ages 7–17 years that yields information relative to affective, cognitive, and behavioral features of depression. Three choices describing symptoms of depression are presented to children, and they must decide which best applies to them.

The Reynolds Child Depression Scale (Reynolds, 1989) is a 30-item self-report questionnaire for children ages 8–12 years. It assesses depressive symptomatology and is intended as a screening measure for depression. The manual recommends that children scoring at or above a specified cutoff score should be referred for further evaluation. Children respond to questions pertaining to feelings, cognitions, and physical signs and symptoms of depression on a 4-point scale ranging from "almost never" to "all the time." The Reynolds Adolescent Depression Scale-2nd Edition (Reynolds, 2002) is similar in purpose and format to the Reynolds Child Depression Scale and assesses symptoms of depression in adolescents ages 11–20 years across four subscales: Dysphoric Mood, Anhedonia/Negative Affect, Negative Self-Evaluation, and Somatic Complaints. The Depression Total score provides an indication of the severity of symptoms reported by the adolescent.

Fear Thermometer ratings have been used to assess level of anxiety or fear in school refusing children. For example, King et al. (1998) used Fear Thermometer ratings on a scale from 0 (no fear) to 100 (maximum fear) to assess self-reported level of anxiety associated with school attendance. Other researchers have used daily ratings to obtain baseline measures of anxiety and to later assess progress in therapy. For example, Kearney and Silverman (1999) used individual logbooks where children rated their anxiety daily on a scale from 0 (none) to 10 (an extreme amount).

Other self-report measures for assessing fear, anxiety, and depression in school refusing children and adolescents include the Fear Survey Schedule for Children-Revised (FSSC-R; Ollendick, 1983), the Negative Affect Self-Statement Questionnaire (NASSQ; Ronan, Kendall, & Rowe, 1994), and the Youth Self-Report (YSR; Achenbach & Rescorla, 2001).

FUNCTIONAL BEHAVIORAL ASSESSMENT

Interview, observation, self-report measures, and parent and teacher ratings all contribute to an understanding of the function of the school refusal behavior. Functional assessment identifies antecedents and consequences to the school refusal behavior (King et al., 1995). Performance situations such as giving speeches and playing competitive games in physical education class are examples of antecedents that may trigger school refusal behavior for some children (Kearney & Beasley, 1994).

Consequences of behavior are assessed in relation to what function the behavior serves for the individual. It is generally agreed that there are two broad functions of behavior: to escape or avoid something that is undesirable or unpleasant (negative reinforcement) and to obtain something that is desired (positive reinforcement). For children who engage in school refusal behavior, escape or avoidance of anxiety-provoking situations are frequently identified functions of behavior (Kearney, 2001).

Kearney and Silverman (1993) developed the School Refusal Assessment Scale-Child and Parent versions (SRAS-C/P) to help identify which of four functions motivate the school refusal behavior. These four functions are (a) avoidance of negative affectivity such as anxiety, depression, and somatic complaints; (b) escape of aversive social or evaluative situations; (c) to seek attention from significant others; or (d) to obtain tangible reinforcement outside of school. The revised version, the School Refusal Assessment Scale-Revised (SRAS-C-R/SRAS-P-R; Kearney, 2002) requires respondents to answer 24 questions on a 6-point scale ranging from "never" to "always." A mean score is calculated for questions related to each of the four functions. The highest mean score of the four is considered to be the primary reason the child is refusing to go to school though there may be more than one function contributing to the behavior (Kearney, 2002; Kearney & Albano, 2000). It is suggested that the SRAS-Revised be used as part of a multidimensional assessment to help identify the function of a child's school refusal behavior. Therefore, when a child scores high on wanting to avoid social or evaluative situations at school, measures of social and emotional functioning (e.g., self-report measures or observation) should be evaluated (Kearney, 2002).

A functional assessment identifies behaviors and associations between their antecedents and consequences. Functional analysis follows functional assessment and allows for hypothesis testing and confirmation of best guess assessments of the function of the child's behavior (Kearney & Albano, 2000). This process involves ongoing manipulation of environmental and other variables surrounding the behavior. For example, does pairing a child with a peer during lunch and recess time help reduce social anxiety/avoidance responses? The assessment form in Appendix A can be used as a guide for conducting a functional assessment and analysis of school refusal behavior.

REFERRALS TO MENTAL HEALTH PROFESSIONALS OUTSIDE OF SCHOOL

The importance of addressing the problem of school refusal in a timely manner cannot be overemphasized. Early identification of the problem and a rapid referral or intervention strategy is recommended to increase the likelihood of success (Kearney & Beasley, 1994). When the school refusal behavior presents as mild, a rapid intervention approach should be considered. More severe or chronic cases should be referred to a mental health professional outside of school for consultation or treatment (Kearney & Beasley, 1994). Though some districts offer school-based clinics or enjoy partnerships with community mental health providers, few are able to provide the level of intensive family or child-based treatment required for severe and/or chronic school refusal behavior.

SPECIAL EDUCATION REFERRAL

Little has been written on the topic of special education referrals for students who exhibit school refusal behavior. Certainly, children who have severe and chronic emotional difficulties such as anxiety or depression that significantly interfere with their school functioning may be considered for a special education referral (e.g., under the emotional behavioral disability category). The National Association of School Psychologists' position statement on special education referrals underscores the importance of early intervention and asserts that referrals for emotional behavioral disability should be considered if "… difficulties have continued despite the use of well-planned, empirically based, and individualized intervention strategies provided within lesser restrictive environments" (National Association of School Psychologists, 2002, p. 1708). Guidelines under the Individuals with Disabilities Education Act should be followed for determining the appropriateness of a referral for a student with school refusal behavior and severe anxiety

TABLE 6

SUMMARY OF ASSESSMENT AND INTERVENTION PLANNING PROCEDURES FOR SCHOOL REFUSAL BEHAVIOR

Initial Screening

- Consult with teacher/parents
- Identify primary behaviors of concern
- Check attendance records for number of days tardy or absent
- Review cumulative file for attendance history and levels of academic functioning
- Make an initial determination of severity
- Determine need for further assessment/referral to team

Interview teacher, parent, student

- Build rapport and trust
- Identify possible contributing variables to the behavior

Medical

- Consult with physician/school nurse
- Determine if there is a legitimate medical concern
- Determine if somatic complaints are related to emotional factors

Identify support system, team members

- Consult with team members
- Collaborate with community-based service providers

Implement assessment methods selected

- Operationally define primary behaviors of concern
- Assess emotional, social, and behavioral functioning
- Identify student strengths, supports
- Identify potential contributing medical, school, family variables, and/or stressful life events
- Identify antecedents and consequences of the school refusal behavior
- Develop hypotheses regarding function(s) of the behavior and determine how hypotheses may be tested

Develop intervention plan

- Establish baseline
- Set goals (e.g., increased attendance, coping skills)
- Select intervention (e.g., child, family, and/or school focused)
- Identify team responsibilities
- Provide ongoing consultation with medical or community-based team members

Monitor intervention plan

- Define follow-up activities and staff member(s) responsible for follow-up
- Revise intervention plan as needed

and/or depression (Individuals with Disabilities Education Act, 1997). Likewise, appropriate steps should be taken for evaluation of school refusers who may have undiagnosed learning, language, or other disorders.

SUMMARY

Assessment and intervention for school refusal behavior is best implemented as a collaborative, team endeavor. Multidimensional assessment provides a full picture of the scope of the problem (e.g., the presence of emotional, behavioral, or learning problems), identifies motivating factors or functions of the behavior (e.g., to avoid anxiety provoking situations), and sheds light on contributing factors that may be maintaining the school refusal behavior (e.g., parents unable or unwilling to take steps to intervene). The purpose of assessment is to guide the development of appropriate, effective interventions that help students develop competencies necessary to achieve consistent school attendance. Table 6 on page 40 provides a summary of primary components for assessment and intervention planning for school refusal behavior.

CHAPTER 4

INTERVENTION

The goal of intervention for school refusal behavior is to increase attendance through a process of helping the child develop necessary competencies and coping strategies. Information gathered through multidimensional assessment of the nature and severity of the behaviors guides this process. During intervention planning, a determination needs to be made whether the problem requires interventions directed toward one or more of the following broad areas: child, medical, family, and school (Kearney & Albano, 2000; Paige, 1993). The presence of multiple etiologies may require that more than one area be addressed (Kearney & Albano, 2000). Intervention should proceed as quickly as possible since early treatment has been linked to good prognosis (Blagg, 1987; Kearney & Beasley, 1994; Paige, 1993, 1997).

Because school refusers are such a diverse group, intervention should be tailored to the particular type of school refusal behavior present. As was discussed earlier, Kearney and Silverman (1990, 1996, 1999) select interventions based on the primary function or reason the child is refusing to go to school. Taylor and Adelman (1990) outline a school district mental health center's model for selecting interventions based on what motivates the child to avoid school (e.g., if the child has difficulty handling schoolwork, then match assignments to the child's ability). Paige (1993) developed a decision matrix for school-based teams to use when planning interventions for school refusal behavior where interventions are selected based on the child's primary problem; for example, use of desensitization when the child exhibits school-related fears.

When an individual child-based intervention such as teaching coping skills or setting up contingencies is selected, teams need to establish who will be responsible for implementing the intervention (e.g., school psychologist, guidance counselor, social worker). If there are medical issues present, then a team member will need to coordinate ongoing consultation with the child's physician. Similarly, a team member may need to engage in ongoing consultation with community-based mental health professionals, case workers, and/or court personnel.

Family issues will be an important consideration when determining the most appropriate intervention for the child. The nature of the problem may indicate a need to teach parents effective strategies for managing their child's behavior such as when a child is refusing school primarily to gain attention (Kearney & Albano, 2000). Finally, school psychologists are well positioned to coordinate modification of school variables that may be contributing to the behavior (e.g., addressing bullying or academic delays).

Following selection of intervention strategies, a procedure for progress monitoring should be developed (Paige, 1993). Progress monitoring is an ongoing process that tracks the progress of interventions. Effectiveness of the intervention is based on how a student progresses on specific behavioral objectives or goals such as increased school attendance and coping skills or a decrease in self-reported anxiety or depression. Attendance patterns can be easily charted for a visual representation of progress.

As was discussed in Chapter 3, changes in anxiety levels associated with school attendance can be tracked using daily or weekly Fear or Feelings Thermometer ratings (Kearney & Albano, 2000; King et al., 1998). Systematic adjustments are applied to interventions as the child's coping skills and attendance improves or conversely, shows a lack of improvement (Callan-Stoiber & Kratochwill, 2002; Kearney & Albano, 2000; Paige, 1993). Appendix B provides a sample form that can be used as a guide for development of an intervention plan and for monitoring its effectiveness.

COMPONENTS OF COGNITIVE-BEHAVIORAL THERAPY FOR SCHOOL REFUSAL BEHAVIOR

Though play therapy, psychotherapy, and family therapy have been used to treat school refusal, King et al. (2000) point out that those approaches are time consuming and have unknown efficacy. As was discussed in Chapter 2, behavioral interventions implemented in the 1960s (Garvey & Hegrenes, 1966; Kennedy, 1965; Lazarus et al., 1965) preceded combined cognitive and behavioral interventions (e.g., Mansdorf & Lukens, 1987). Treatment research conducted in recent years has focused primarily on cognitive-behavioral interventions for school refusal indicating their potential effectiveness for this population of children (King et al., 2000).

Cognitive-behavioral therapy for school refusal applies some or all of the following strategies: coping skills training (e.g., relaxation, cognitive restructuring), exposure, and contingency management (King et al., 2000). Other strategies may include psychoeducation (teaching children about anxiety), social skills training, parent training, teacher consultation, goal-setting, shaping, modeling, and assignment of homework tasks. With anxious children, cognitive-behavioral therapists act as consultants and collaborators to help the child understand anxious thoughts and feelings, teach the child coping strategies, and help the child use those strategies during exposure situations. Cognitive-behavioral therapists help children develop problem solving skills to use when confronted with anxiety-provoking situations (Kendall, Chansky, et al., 1992). Cognitive-behavioral treatment for school refusal behavior has been applied either as a multiple component treatment package (e.g., King et al., 1998) or as a prescriptive approach where treatment is matched to the function of the child's school refusal behavior (e.g., Kearney & Silverman, 1999).

The major components of cognitive-behavioral intervention for school refusers are described below along with a discussion of the applicability of forced school attendance versus gradual exposure/re-entry to school.

RELAXATION TRAINING

Relaxation training is taught to anxious children as a coping strategy to use when confronted with anxiety-provoking situations. During progressive muscle relaxation training, anxious children are taught to relax the major muscle groups through tense-release exercises. Children are taught to recognize the difference between when their muscles are tense and when they are relaxed. The premise is that relaxation is incompatible with a tensed, stressed state. Developmentally appropriate relaxation training scripts are available for children (Ollendick & Cerny, 1981). Kearney and Albano (2000) combine relaxation training with training in deep diaphragmatic breathing for children who refuse school due to general distress/negative affectivity.

SYSTEMATIC DESENSITIZATION

Following relaxation training, systematic desensitization is frequently introduced as a strategy to help children reduce anxiety associated with school refusal (e.g., Kearney & Albano, 2000; King et al., 1995). A hierarchy of anxiety-provoking situations is developed in accordance with the feared situation for a particular child. King et al. recommend constructing a list of 10–20 situations recorded on index cards, graduated by level of fear. For example, step one may be the child visits the empty school grounds on a weekend, and step two may involve sitting in the car outside of school on a school day. The process continues with having the child gradually enter the building when no other students are present. The next step would be having the teacher or one other student present. The child could eventually attend school with students during a limited number of classes followed by half-day and, finally, full-day attendance (King et al., 1995).

The graduated hierarchy of anxiety-provoking situations is used during both imaginal and in vivo (real life) systematic desensitization. During imaginal desensitization, children imagine an anxiety provoking scene of graduated difficulty while practicing relaxation. During in vivo desensitization, children practice relaxation while actively confronting anxiety provoking situations of increasing difficulty. Fear Thermometer ratings of anxiety are typically used during this process to gauge level of anxiety.

Relaxation training and systematic desensitization are appropriate for children who experience anxious arousal and extreme avoidance, but are not the treatment of choice for children who refuse school to gain a desired activity or for attention (Kearney, 2001; Kearney & Albano, 2000; King et al., 1995).

COGNITIVE RESTRUCTURING

Cognitive restructuring of anxious self-talk is based on the premise that maladaptive thoughts produce maladaptive behaviors and can be changed to produce more adaptive self-talk and behaviors (Kendall, Chansky, et al., 1992). The idea that thoughts, feelings, and behaviors are interactive and causally linked has been forwarded by Ellis (1962), Beck (1976), and Meichenbaum (1985). Cognitive therapy was initially developed for use with adults (e.g., Meichenbaum, 1985) and later modified for use with anxious children (e.g., Kendall, 1994; Kendall et al., 1997; Last et al., 1998). Kendall has conducted extensive research in cognitive-behavioral therapy for anxious children and has developed a manual-based, multicomponent cognitive-behavioral treatment program (Kendall, 1994; Kendall et al., 1997; Kendall, Kane, Howard, & Siqueland, 1992).

REDUCING NEGATIVE SELF-TALK

During cognitive restructuring, the therapist's role is to help identify and modify cognitive distortions (Kendall et al., 1988). Cognitive distortions are misperceptions of events that are influenced by dysfunctional thinking processes. An anxious child's tendency to perceive events as dangerous when very little danger is present, for example, would be considered a cognitive distortion. Similarly, an anxious child's thoughts that he or she will be unable to complete a task because of lack of ability when having performed quite well in the past is another example of a cognitive distortion. The self-talk accompanying such a distortion might be "I'm stupid," or "I can't do this."

During cognitive restructuring, a goal is to reduce the amount of negative self-talk rather than simply focusing on increasing positive thoughts (Kendall, Chansky, et al., 1992). Similarly, Kearney and Albano (2000, p. 84) emphasize "healthy thinking," which focuses on realistic problem solving and adaptive thoughts. Of course, analysis of self-talk with children needs to be developmentally appropriate. Therefore, some clinicians working with anxious children use cartoon figures with thought bubbles to demonstrate the idea of self-talk (King et al., 1995). This technique is based on Kendall, Kane, et al's. (1992) cognitive-behavioral treatment program for childhood anxiety. For example, a cartoon figure thinking, "I can't do this test," would be modified to illustrate a more adaptive, problem-solving approach (e.g., "How can I best get through these test questions?").

Cognitive restructuring of anxious self-talk was used by Mansdorf and Lukens (1987) who taught two children with severe school phobia how to use coping self-statements to reduce anxiety regarding school attendance. For example, one child's self-talk included the statement, "'I'm scared for my mother when she goes.'" Therefore, a suggested coping statement was, "'My mother can care for herself well'" (p. 224).

PROBLEM-SOLVING STEPS

The process of modifying anxious self-talk is typically used in conjunction with teaching the child steps to use within a problem-solving paradigm (Kearney & Albano, 2000; Kendall, Kane, et al., 1992; Silverman & Kurtines, 1996). The child is taught to (a) recognize when they are stressed or afraid, (b) identify their feelings and thoughts, (c) implement more adaptive thoughts or other coping strategies, and (d) reinforce themselves for using the coping strategies during difficult situations.

COGNITIVE RESTRUCTURING AND EXPOSURE

Cognitive restructuring generally culminates with gradual exposure to the anxiety-producing situation or object. Prior to the exposure, role play is used with a graduated hierarchy of situations related to the child's fear. During role play, the therapist helps the child analyze and develop more adaptive self-talk. The development of a graduated hierarchy of feared situations allows for the rewarding of successive approximations of desired behaviors (shaping). For example, rewards are implemented for graduated school re-entry beginning with a tolerable task such as the child visiting school prior to school starting in the morning. Gradually, as the child feels more comfortable, the approach tasks increase to full day, satisfactory attendance (King et al., 1995; Silverman, 2002).

CONTINGENCY MANAGEMENT

Contingency management is frequently used to increase the value of school attendance through social (peer and parent approval) and tangible rewards while reducing the reinforcing value of staying at home (King et al., 1995). The strategy is based on operant conditioning principles and often applies shaping and differential reinforcement. For example, shaping and differential reinforcement of appropriate behaviors were implemented for a child whose school refusal was due to attention getting/separation anxiety (Kearney & Silverman, 1990). Parents were to withhold attention if the child remained home from school, thus reducing the reinforcing value of staying home. Contingencies were arranged with a goal of increasing school attendance and reducing tantrum behavior and somatic complaints. The child was required to remain in his room during the school day and for periods on weekends and complete homework at night. Privileges (e.g., bike riding) were awarded and weekend room restrictions were reduced in exchange for gradual school attendance (two weekdays gradually increased to five). Following treatment, school attendance was increased from 69.6% school days missed to regular attendance at post-treatment and six-month follow-up. Regular attendance was defined as not having missed any days of school outside of legitimate physical illness.

Differential reinforcement of appropriate behavior combined with planned ignoring of target behaviors was used to reduce school refusal behavior for a 10-year-old girl diagnosed with separation anxiety disorder and social phobia (Chorpita et al., 1996). The function of the girl's school refusal behavior was determined to be attention getting/separation anxious based on results from the School Refusal Assessment Scale (SRAS; Kearney & Silverman, 1993). Treatment was applied according to a multiple baseline design across four target behaviors: (a) somatic complaints, (b) anger and tantrums, (c) tears, and (d) other complaints. Treatment was introduced for each behavior successively and involved having the parents ignore target behaviors for the week. Appropriate activities (e.g., cooking) were introduced so the child could receive much praise and positive attention. Following intervention at two-week and 24-month follow-up, targeted behaviors were reduced to a frequency of zero occurrence. At post-treatment, the diagnoses of separation anxiety disorder and social phobia were assessed through an independent evaluator and found to be in full remission. The child did not meet criteria for any diagnosis at 24-month follow-up.

SOCIAL SKILLS TRAINING

Social skills training for school refusers involves helping children manage anxiety associated with social interactions with peers and adults. Social skills training helpful for children who avoid school because of social or performance anxiety may include making and keeping eye contact, starting and joining conversations, and assertiveness (Kearney & Albano, 2000). Social skills training combined with exposure for children with general social phobia was found to be beneficial by Beidel, Turner, and Morris (2000) who used training in greetings and introductions, in starting and maintaining conversations, in listening and remembering skills, in how to join groups, in positive and negative assertion, and in telephone skills.

FAMILY INTERVENTIONS

Parent training for children exhibiting school refusal behaviors frequently involves teaching effective behavior management strategies and training in contingency management (King et al., 1995). In a survey of 63 professional psychologists regarding preferred treatment strategies for school refusal, parent training/contingency management was reported to be the most frequently used method (Kearney & Beasley, 1994) Parent training may include teaching parents how to restructure commands to be more effective, teaching parents how to ignore simple inappropriate behavior, and teaching parents how to establish routines, rewards, and consequences (Kearney, 2001; Kearney & Albano, 2000).

Paige (1993) recommends that school-based teams make the following determinations regarding parental involvement in intervention planning: (a) decide which team member consults with the parents (e.g., school psychologist, social worker, guidance counselor); (b) educate parents about school refusal and its causes and provide support and training; (c) determine whether a family member is willing and able to assist with intervention; and (d) if parents are unable or unwilling to participate in school re-entry plans, then identify a family member and/or school staff member to assist with bringing the child to school.

Hargett and Webster (1996) used a graduated re-entry intervention combined with positive reinforcement for staying in school and minimization of the reinforcing influence of the child's mother. The boy, age 7 years, 10 months, developed excessive fear related to school, was reading well below grade level, and had few friends. He would refuse to attend school and, when there, developed a pattern of running away from school during the morning. It was determined that the boy was allowed to watch television, play video games, and engage in other reinforcing activities when staying home from school. A behavioral contract was developed, and a plan for gradual attendance beginning with half days was agreed upon. The grandmother was enlisted to bring the child to school after determining that parental support was not available. Satisfactory attendance was maintained for seven months following the intervention and during the first six weeks of the following school year.

Doll (1987) used a family-based consultation approach that included goal-setting, reinforcement, self-monitoring, relaxation training, support for the child, and parent education to increase school attendance for four children with school refusal. Though the treatment incorporated several components, the author stressed the importance of family-based consultation versus strictly child-based consultation to address maladaptive family interaction patterns and provide both the child and family strategies for coping with the school refusal behaviors.

Certainly having a child who refuses to go to school can cause severe stress for parents and other caregivers. Accordingly, cognitive-behavioral strategies have been used to assist parents with stress management (King et al., 2000). In cases where parental psychopathology is severe and a major or primary factor contributing the school refusal behavior, King et al. (1995) recommend that treatment should initiate with the parents.

Just as there are multiple etiologies contributing to school refusal, there is a range of parental functioning. Indeed, some families who have children who refuse to attend school are healthy functioning and show no pathology (Kearney & Silverman, 1995).

GRADUAL RE-ENTRY VERSUS FORCED SCHOOL ATTENDANCE

There has been a considerable amount of interest in the literature regarding whether children benefit more from a process of gradual school re-entry versus immediate, forced school attendance. Kennedy (1965) reported success in using forced school attendance with children exhibiting acute school refusal (rapid onset with no prior history of school refusal). Blagg and Yule (1984) used a school refusal treatment program consisting of in vivo flooding, positive reinforcement for school attendance, parent use of contingency management, and teacher consultation to ensure smooth, school re-entry. The authors reported superior outcome for children receiving the behavioral treatment (*n* = 30) as compared to home-tuition and psychotherapy (*n* = 20) or hospitalization (*n* = 16).

The advantages of forced, immediate school attendance are that school refusal behaviors have less time to become reinforced and the secondary reinforcement of staying home is minimized (Hargett & Webster, 1996). However, forced school attendance can be extremely stressful for all involved (King et al., 2000). Kearney and Beasley (1994) recommend forced school attendance in combination with parent training be considered by school personnel if the problem is mild or in very acute cases that have presented for less than two weeks. Kearney (2001) and Kearney and Albano (2000) assert that forced school attendance should be used with great caution and only if the child is refusing school for attention, if the child shows little distress or anxiety about school, if the parents are willing to take the child to school (two parents or one parent and another adult), if school staff is willing and able to supervise the child for the day, and if the child is under the age of 11. For cases of longer duration and with children who are extremely anxious or depressed, a gradual school re-entry approach has been suggested (Kearney, 2001; Kearney & Albano, 2000; Kearney & Silverman, 1999).

It is important to enlist school staff to be supportive of school re-entry efforts. Taylor and Adelman (1990) note that an onsite advocate who welcomes the student back to school increases the potential for successful school re-entry. Efforts need to be taken to ensure that school staff is aware of re-entry plans so that the possibility of negative staff interactions with the student are minimized.

COGNITIVE-BEHAVIORAL TREATMENT STUDIES

Recent studies investigating cognitive-behavioral intervention for school refusal have involved case studies or single/multiple case design (e.g., Chorpita et al., 1996; Hargett & Webster, 1996; Kearney, Pursell, & Alvarez, 2001; Meyer, Hagopian, & Paclawskyj, 1999), open clinical trials (Kearney & Silverman, 1990), and controlled studies (Bernstein et al., 2000; Kearney & Silverman, 1999; King et al., 1998; Last et al., 1998).

King et al. (1998) treated a group of 34 school refusers ages 5–15 years using a multicomponant cognitive-behavior therapy approach in a randomized clinical trial. Children were identified as exhibiting severe school refusal over a three month period: 10 were completely absent from school, 17 experienced intermittent or partial attendance, and 7 attended school but with anxiety and resistance. Clinical diagnoses were primarily anxiety or phobic disorders, with separation anxiety being most prevalent. The children were randomly assigned to a six session cognitive-behavior treatment (*n* = 17) or wait-list control group (*n* = 17). The cognitive-behavioral treatment was facilitated by a therapist manual influenced by Kendall's manual-based treatment for childhood anxiety disorders (Kendall, 1994; Kendall, Kane, Howard, & Siqueland, 1990). Broad intervention strategies were child cognitive-behavioral treatment, parent, and teacher training. Child treatment components included goal-setting, teaching coping skills for anxiety-provoking situations, relaxation training, teaching children to recognize and address anxiety producing self-talk, teaching assertive behaviors, applying coping skills to imaginal and in vivo situations presented in hierarchical order, and gradual school re-entry (i.e., beginning with half-day or single-class attendance). Other strategies included praise, modeling, and completion of homework tasks.

Parent training emphasized "smooth household routines and ignoring somatic complaints and negative comments about school" (King et al., 1998, p. 398). Parents were trained in use of tangible reinforcement and praise for the child's use of coping behaviors and school attendance and firm, consistent discipline practices. Teacher consultation allowed for discussion of positive behavioral strategies (e.g., welcoming greetings and/or providing a peer buddy to ease social anxiety or help with bullying situations) and telephone contact to monitor progress.

The authors defined clinically significant improvement as attending school 90% of the time or more. Post-treatment results were that 88.23% of children who received cognitive-behavioral therapy attended school 90% of the time or more. At post-treatment, 29.41% of the children in the control group demonstrated clinical improvement in school attendance. In addition to increased attendance, children who received cognitive-behavioral therapy showed improvement in other areas such as self-reported fear, anxiety, depression, coping skills, and caregiver and clinician ratings. Gains were maintained at three-month follow-up. The authors observed that including parents and teachers was an important component contributing to the success of the intervention. Limitations of this study were the absence of follow-up data for the wait-list control group, though the authors point out that it was not feasible for ethical reasons to withhold treatment for those in the control group (King et al., 1998). Additionally, the study lacked a placebo control group to account for variables that may have resulted in improvement such as therapist attention.

Last et al. (1998) investigated the effectiveness of cognitive-behavioral therapy with a group of 56 children ages 6–17 years identified as exhibiting school refusal using a randomized clinical trial with attention-placebo control group. Lack of school attendance was defined as absent for at least 10% of classes for at least one month prior to evaluation. Children included in the study were identified as exhibiting anxiety-based school refusal (e.g., simple or social phobia, separation anxiety disorder), with those diagnosed with major depression excluded from the study. The children were randomly assigned to a 12-week cognitive-behavioral therapy program or attention-placebo control group. The cognitive-behavioral treatment consisted of graduated in vivo exposure and coping self-statement training. A hierarchy of anxiety-provoking school situations was developed, and homework assignments were completed. Coping self-statement training involved teaching children to identify and modify maladaptive thoughts surrounding anxiety-provoking school situations.

The educational-support therapy was used as a placebo to control for variables that may have accounted for improvement such as therapist attention and expectations for improvement. Educational-support therapy consisted of educational presentations and supportive psychotherapy. Children talked about their fears, learned to distinguish between fear, anxiety, and phobias, and kept a daily diary about their fears, thoughts, and feelings

(Last et al., 1998). Unlike the children in the cognitive-behavior therapy group, these children were not provided information on how to confront anxiety-provoking situations, taught how to modify self-talk, or involved in a process of direct instruction to gradually increase their exposure to school.

Results were that both groups showed clinically significant improvement at post-treatment and four-week follow-up in school attendance and on symptoms of anxiety and depression. The unexpected finding that educational support therapy and cognitive-behavior therapy both produced significant improvement in attendance lead the authors to hypothesize that children in the educational support treatment may have been able to modify their own maladaptive self-talk even though not specifically taught how to do so. Approximately 30% of children in both groups reported experiencing difficulty returning to school the following year. The authors observed that this finding underscores the need for booster sessions and sensitivity to trigger events such as returning to school for a new school year, after holidays, or weekends (Last et al., 1998).

With multiple component cognitive-behavioral treatment, it is often unclear which specific components are most effective (King et al., 2000). Indeed, some children may not require all the components included in a multiple component treatment package (Kazdin & Weisz, 1998). Response to treatment may depend on factors such as type of anxiety, the age of the child, severity, and family issues (Last et al., 1998). Accordingly, there has been increasing interest in prescriptive treatment as an efficient approach to treating problems which present with multiple etiologies (Ollendick & King, 1999). Prescriptive treatments match intervention to the child's problem. Preferred prescriptive treatment for each of four categories of school refusers have been developed by Kearney and Silverman (1990, 1996, 1999) and further outlined by Kearney (2001) and Kearney and Albano (2000). See Table 7 on page 54 for a summary of prescriptive treatment for each of four categories of school refusers.

Use of prescriptive treatment for school refusal behavior for eight children ages 6–16 years was investigated by Kearney and Sliverman (1999). Prescriptive treatment was assigned based on the function of the child's school refusal behavior assessed with the SRAS (Kearney & Silverman, 1993). There was a pretreatment mean of 42.6% time out of school for both groups. Through parent and child SRAS ratings, a determination was made regarding which of four functional conditions provided the primary motivation for school refusal behaviors: (a) avoidance of stimuli provoking negative affectivity, (b) escape from aversive social or evaluative situations, (c) attention seeking, or (d) desire for positive tangible reinforcement outside of school (Kearney & Silverman, 1999). Following SRAS analysis, treatment was matched to the function of the behavior for four of the children participating in the study. For example, cognitive therapy and increased daily activity was

TABLE 7

PRESCRIPTIVE TREATMENT FOR FOUR FUNCTIONAL CATEGORIES OF SCHOOL REFUSAL BEHAVIOR

Category	Treatment
1. Children who refuse school to avoid situations that produce negative affectivity (i.e., anxiety, depression, somatic complaints)	Construction of an anxiety/avoidance hierarchy, relaxation and breathing training, gradual exposure, self-reinforcement, praise
2. Children who refuse school to escape aversive social or evaluative situations	Cognitive therapy to reduce social anxiety, modeling, role play, gradual exposure
3. Children who refuse school in order to seek attention from significant others	Training parents in contingency management, restructuring parent commands, establishing smooth household routines
4. Children who refuse school to pursue tangible reinforcement outside of school	Family contingency contracting to increase rewards for school attendance and decrease rewards for missing school

Note: Based on Functionally Based Prescriptive and Nonprescriptive Treatment for Children and Adolescents With School Refusal Behavior, by C. A. Kearney and W. K. Silverman, 1999, Behavior Therapy, 30, pp. 673–695. Copyright 1999 by the Association for Advancement of Behavior Therapy. Reprinted by permission of the publisher.

prescribed for a child with a DSM-IV diagnoses of generalized anxiety disorder and major depression whose primary function of school refusal behavior was escape from aversive social and evaluative situations. Four of the children received what was considered nonprescriptive treatment and was later followed by prescriptive treatment. Results were that all four children receiving prescriptive treatment increased attendance to full-time with reductions in daily ratings of anxiety and depression. Conversely, there was an increase in percentage of time absent from school and higher levels of daily ratings of anxiety and depression for children receiving nonprescriptive treatment. Limitations of this study were small sample size, lack of a daily measure of morning noncompliance related to school avoidance, and lack of control for other strategies families may have used to try to get their child to go to school (Kearney & Silverman, 1999).

After reviewing the literature on cognitive-behavior therapy for school refusal, King et al. (2000) observed that children presenting with anxiety-based school refusal benefit "quite remarkably from such intervention, in terms of anxiety reduction, increased self-efficacy, and improvement in school attendance" (pp. 505–506). The authors reviewed the literature (i.e., case studies, open clinical trials, and nonrandomized clinical trials) and two randomized, controlled cognitive-behavior therapy studies for school refusal (King et al., 1998; Last et al., 1998). They noted that cognitive-behavior therapy is a "useful" intervention for school refusal (King et al., 2000, p. 495). However, additional controlled studies should be completed before cognitive-behavior therapy can be considered well established or probably efficacious in treating school refusal (King et al., 2000). The guidelines for determining when a treatment is considered empirically supported were developed by the American Psychological Association's Division 12 task force on Promotion and Dissemination of Psychological Procedures and are outlined in Chambless et al. (1996).

MEDICATION

Medication for the treatment of school refusal has been investigated by several researchers over the years (see reviews in Bernstein et al., 2000; Kearney, 2001; King & Bernstein, 2001; and King et al., 1995). King et al. reviewed the use of medication for school refusal and concluded that it should be used with caution because of the possibility of serious side effects and only when other psychological treatment has been ineffective and when symptoms are considered severe.

Medication in conjunction with cognitive-behavioral therapy for school refusing adolescents with severe symptoms (i.e., the presence of both anxiety and major depression) was investigated by Bernstein et al. (2000). The authors compared eight weeks of the antidepressant imipramine to placebo in combination with manual-based cognitive-behavioral therapy for adolescents ages 12–18 years with comorbid anxiety and major depressive disorders. Sixty-three subjects were randomly assigned to the two groups with 47 subjects completing the study. Though anxiety and depression ratings decreased significantly following treatment for both groups, the decrease in depression ratings was significantly faster for the imipramine plus cognitive-behavior therapy group. Following treatment, 54.2% of the adolescents who received imipramine plus cognitive-behavioral therapy met the attendance goal (defined as 75% of school hours or better) compared to 16.7% of the placebo plus cognitive-behavioral therapy group. There was a significant difference in average attendance rates between the two groups in the final week of treatment (70.1% for the imipramine group and 27.6% for the placebo group).

The authors noted that the presence of major depression may have reduced the participant's ability to benefit from the cognitive-behavioral therapy. They point out that other studies finding cognitive-behavior therapy (without medication) as beneficial for school refusers, have included primarily children with anxiety disorders excluding children diagnosed with major depression (Last et al., 1998) or including just one child with dysthymia (King et al., 1998). Limitations of this study as outlined by the authors included the presence of "an ethnically homogeneous sample, lack of a psychiatric control group (e.g., subjects with anxiety disorders only), and a relatively short duration of treatment" (Bernstein et al., 2000, p. 282). Another limitation was that, by chance, subjects in the placebo group scored higher than the imipramine group on anxiety and depressive rating scales at post-placebo washout baseline (Bernstein et al., 2000).

Bernstein, Hektner, Borchardt, and McMillan (2001) found that at one-year follow-up of 65% of the subjects included in the Bernstein et al. (2000) study, 64.1% and 33.3% met criteria for an anxiety and depressive disorder respectively with 25.6% having comorbid anxiety and depressive disorders. Many of the follow-up subjects had received mental health treatment (psychotropic medication and/or psychotherapy). Although no attendance rates were available, most subjects attended school during the year following the intervention study. Some subjects had been hospitalized (20%) or placed outside the home (15%). The authors observed that results of this study underscore the severity of school refusal for children with severe symptoms such as comorbid depression and anxiety and point to the need for further investigation into optimal length of treatment with severe cases and factors that contribute to maintenance of treatment gains (Bernstein et al., 2001).

ADDRESSING SCHOOL VARIABLES

As was discussed in Chapter 2, school variables can contribute to school refusal behavior. Some students avoid school because of severe anticipatory anxiety about tests or other performance or social situations. Other students may avoid school as a result of academic difficulties. Still others dread going to school because they fear they may be threatened, teased, or even physically harmed. When factors such as those are found to influence a child's school refusal behavior, strategies that address school variables and/or support the child within the school environment should be considered by teams planning interventions.

Providing teachers with information about early warning signs of school refusal can help prevent the development of school refusal or prevent problems from moving from mild to severe. Timely and efficient assessment and intervention by knowledgeable staff within the school may eliminate the need for referral to community mental health professionals (Blagg & Yule, 1984; Elliott & Place, 1998). Warning signs of school refusal behavior are outlined in the handout found in Appendix C. Warning signs include a pattern of worrying about parents while at school, repeated requests to call home, recurrent somatic complaints, a pattern of tardiness or absence, or absences on critical days such as scheduled tests or physical education class times. Providing teachers with information regarding school refusal through consultation or inservice presentation can help dispel the notion that school refusal is always due to a problem within the family but rather can be a manifestation of an aversive school situation (King et al., 1995).

Clearly, teachers are key to the success of classroom-based academic and behavioral interventions. Though many are well versed in implementation of positive behavioral supports for students, even the most experienced teachers benefit from close consultative support when implementing interventions with school-refusing children. In cases where a change in teachers is considered, King et al. (1995) recommend the change be viewed as establishing a "goodness-of-fit" between teacher and student (p. 147). Here the importance of matching student to teaching style is emphasized. Changing schools is generally not recommended though may sometimes be used as a "last resort" (King et al., p. 146). Likewise, home schooling, home tuition, or homebound instruction is generally not recommended (Blagg & Yule, 1984; Elliott & Place, 1998; Want, 1983). Want (1983) points out that remaining at home does not allow the child to experience the "stabilizing" influence of school (p. 29).

For some extreme cases of school refusal behavior (e.g., school absence for over 2 years, extremely severe levels of anxiety and depression) alternative educational programming such as part-time schooling may need to be considered as part of a comprehensive intervention plan (Kearney, 2001; Kearney & Albano, 2000).

Children with separation anxiety benefit from a welcoming environment that provides consistent and firm expectations. King et al. (1995) outline the following suggestions for helping separation anxious school refusers: (a) welcome the child when the child gets off the bus or walks into school, (b) walk the child into the school and/or classroom, (c) give the child special jobs to help in the classroom in the morning, and (d) train school personnel in managing behaviors such as ignoring crying and somatic complaints while reinforcing positive behaviors. Providing a mentor or peer buddy can help support the separation or socially anxious child. A mentor can be a trusted teacher, school psychologist, guidance counselor, or social worker. The Center for Mental Health in Schools at UCLA (2001) stresses the need to create a positive, psychologically attractive school environment and suggests using peer buddies or personal invitations to join activities to ease stress during transition times such as a new school year or when a child changes schools. Some schools provide a safe port in the school nurse's office until the student gradually feels more comfortable (Okano & Tsuchiya, 1999). Elliott and Place (1998) recommend that the school provide a quiet area the child can utilize before school or during critical times if the child feels panicky or angry.

School personnel should be alert to the possibility that students who avoid school may be experiencing severe anticipatory anxiety and/or negative affectivity surrounding social or performance situations (Kearney & Beasley, 1994). Students need to feel safe from being embarrassed, made fun of, or ridiculed by others at school (King et al., 1995). Blagg (1987) suggests that in the early stages of school re-entry for children with performance anxiety to be careful not to single out students to, for example, read out loud in class. Missed school work may need to be forgiven or tutoring provided. Staff may need to brainstorm strategies to address issues related to physical education class such as anxiety related to competitive or performance situations or a student's desire to avoid the locker room or showers.

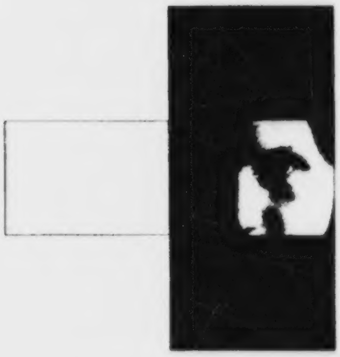
The potential that a child's school refusal is a normal reaction to an aversive school environment or specific situation should be considered (Merrell, 2001). Children who feel threatened at school may be responding to very real situations such as when a child is bullied or left out (Pilkington & Piersel, 1991). Typically, efforts to reduce bullying incorporate school-wide, classroom-wide, and individual components (e.g., Center for the Study and Prevention of Violence, 2002; Olweus, 1993). School-wide initiatives involve developing anti-bullying policies and increasing supervision in problem areas of the school where bullying is most frequent such as bathrooms, buses, and in the hallways. Effective anti-bullying policies address not only overt acts of aggression but more subtle forms of bullying such as put downs, teasing and excluding others, or starting rumors. At the classroom level, staff is trained how to identify and respond to bullying and how to hold class meetings. At the individual level, children are taught how to handle themselves in situations where they feel threatened through supportive counseling, conflict resolution, and/or assertiveness training. Parents are provided with information regarding how to respond when their child is a victim of bullying. Students are helped to feel that that they are not alone and that adults at school will assist them when they feel threatened or excluded.

Anti-bullying initiatives are one component of the broader issue of school climate. School climate variables that have been identified as contributing to school refusal behavior include large class size, too much emphasis on competition, and poor staff morale (Pilkington & Piersel, 1991). For the interested reader, Lehr and Christenson (2002) review strategies for assessing and improving school climate.

SUMMARY

Intervention for school refusal behaviors may be directed toward one or more of the following areas: child, medical, family, or school. Research conducted in recent years indicates the potential usefulness of cognitive-behavioral interventions for school refusal behavior, though it has been suggested that further controlled studies are needed before it be considered well established or probably efficacious (King et al., 2000). Prescriptive cognitive and behavioral interventions for school refusal behaviors were outlined. A prescriptive approach addresses the extreme diversity of school refusers by aligning treatment with the primary function or reason for the child's school refusal behavior.

School variables that may need to be addressed include helping separation and socially anxious children feel more comfortable, consulting with teachers on behavioral strategies, and addressing bullying or academic delays. A process for school-based teams to use for selecting interventions and progress monitoring was suggested. A collaborative, team-based approach is recommended with the goal of intervention being increased school attendance and elimination of school refusal behaviors.



CHAPTER 5

CASE ILLUSTRATION

Conner, a 6-year-old boy in kindergarten, was referred to the school psychologist by his teacher for crying episodes at school that were occurring almost daily. Parent interview revealed that morning battles regarding school attendance (crying, whining, complaining about school) occurred three to four times per week. Other concerns were frequent nighttime complaints about going to school, sleep disturbance, nightmares, and somatic complaints with no apparent physical basis. Tantrums regarding school attendance occurred at home and often continued until the school parking lot when Conner's mother had to guide him, crying, into the building. Detailed parent interview revealed the presence of separation anxiety. Conner, an only child, demanded much of his parents' attention and showed reluctance when encouraged to participate in community activities such as tee-ball. His parents were supportive and willing to work on resolving the problem.

Teacher interview revealed that Conner was making good progress in the kindergarten curriculum and was well liked by his peers. Observation revealed a pattern of crying episodes prior to school and at mid-morning during unstructured play time. It was noted that crying was reduced when Conner was given special jobs to do immediately after coming to school in the morning (e.g., helping the teacher pass out papers).

Conner reported during the child interview that he liked school but cried because he missed his mother. Conner's mother completed the Child Behavior Checklist (CBCL;

Achenbach, 1991a) that indicated clinically significant problems on the Somatic Complaints (SS 70) and Anxious/Depressed (SS 74) scales (above the 97th percentile). The total Internalizing grouping rating was in the clinically significant range (SS 74). All other scales were rated within normal limits. Conner's teacher completed the Teacher Report Form (TRF; Achenbach, 1991b) that indicated ratings within normal limits on all scales.

The eight-week intervention plan agreed upon by the teacher, parent, and school psychologist involved setting up home and school contingencies to reduce crying episodes and somatic complaints. Additionally, counseling sessions were scheduled two times per week with the school psychologist to teach Conner coping strategies to use when he felt anxious (e.g., go play with a friend during morning, unstructured play time). A goal was set to reduce school and home crying episodes to zero occurrence following intervention. Progress would be monitored through daily frequency counts of crying episodes and weekly Fear Thermometer ratings. Fear Thermometer ratings were based on a 5-point scale with 5 representing the highest rating *(very much scared or worried)*.

Following intervention, Fear Thermometer ratings were reduced from pre-intervention scores around 4 *(very scared or worried)* to scores of 1–2 *(happy, not scared at all to a little scared or worried)*. Crying episodes were reduced to zero occurrence at school. Crying episodes, though slightly reduced to approximately one to two times per week, continued to be present at home prior to coming to school in the morning. Post-intervention CBCL parent ratings indicated Somatic Complaints scale ratings were unchanged (SS 70). Anxious/Depressed scale and Total Internalizing grouping ratings were reduced (SS 68). All other scales continued to be rated below clinically significant levels. The TRF ratings remained within normal limits.

This case illustrates a relatively mild presentation of school refusal since evidence suggests that younger children and those with higher pre-intervention attendance levels respond better to intervention (Last et al., 1998). Conner did not stay home completely from school, had good academic and social skills, and parents who were able and willing to implement interventions. The fact that crying episodes continued to be present at home indicated a need for more intensive parent training than the two sessions that had been provided during the intervention.

What follows are filled-out samples of the Assessment Form for School Refusal Behavior and the Intervention Planning Form for School Refusal Behavior. (Copies of these forms are in Appendix A and Appendix B.)

SAMPLE ASSESSMENT FORM FOR SCHOOL REFUSAL BEHAVIOR

Name: *Conner*	Grade: *K*
DOB: *10/07/95*	Date: *02/01/02*

1. Identify primary concerns.

   Crying episodes at school and home.
   Frequent somatic complaints particularly at home.

2. Describe the frequency of the school refusal behavior. Include number of absences, days tardy, and/or frequency of conflicts with school staff or parents regarding school attendance.

   Crying episodes begin at home and continue at school in the morning three to four times per week. Crying episodes at mid-morning unstructured play time occur three to four times per week. This has occurred for approximately one month. Prior to that crying episodes were present but less frequent.

3. Summary of assessment data (e.g., interview, observations, self-report measures, behavior ratings). Include relevant information regarding emotional/behavioral functioning, skill deficits, medical, school, family, and/or stressful life events.

   Parent and teacher interview suggests separation anxiety is present.

   Observation indicates morning before school crying is reduced when Conner is given special jobs to do in the classroom (e.g., pass out papers, collect books).

   Fear Thermometer rating 4 (very scared or worried) regarding leaving mother.

   Clinically significant CBCL parent ratings on the Somatic Complaints (SS 70) and Anxious/Depressed (SS 74) scales (above the 97th percentile). Total Internalizing grouping rating (SS 74). All other scales ratings are within normal limits. Teacher TRF ratings are within normal limits.

4. Describe student's strengths (support system, within child factors).

   Parents are supportive, willing, and able to implement interventions.
   Conner is making good progress in the kindergarten curriculum, is well liked by peers, and has good social skills.

Form continued on page 64

Form continued from page 63

5. Describe antecedents to the behaviors. What happens before the behavior occurs?

   Parent leaves and/or there is unstructured play time. Conner appears to cry because he misses his mother during school.

6. Describe the consequences. What happens after the behavior occurs? Identify possible functions of the behavior.

   Conner receives attention from parent, teacher, and peers. Teacher provides reassurances and tries to get Conner involved in schoolwork. Crying generally lasts for approximately 15–20 minutes. Anxiety associated with being away from his mother results in a desire to go home (escape or avoid school).

SAMPLE INTERVENTION PLANNING FORM FOR SCHOOL REFUSAL BEHAVIOR

Name: *Conner*
Grade: *K*
DOB: *10/07/95*
Date: *02/08/02*

1. Summarize assessment data. Include emotional/behavioral characteristics, skill deficits, medical, school, family, and/or stressful life events contributing to the behavior.

   Parent and teacher interview suggests the presence of separation anxiety. Observations are that crying decreases when Conner is given special jobs to do in the morning just prior to school starting.

   CBCL: Clinically elevated Anxious/Depressed and Somatic Complaints scale ratings.

2. What appears to be the cause or function of the school refusal behavior; for example, to escape or avoid an anxiety producing situation, to gain attention, to obtain a desired activity?

   Conner becomes anxious at school because of anxiety regarding separation from his mother resulting in crying, frequent somatic complaints, and requests to go home. Anxiety surrounding separation results in a desire to escape from or avoid school. Conner receives a considerable amount of attention for his behaviors.

3. Select goals (e.g. increase attendance, increase coping skills).

   - *Reduction of crying episodes during school to zero per day.*
   - *Reduction of morning crying episodes at home to zero.*
   - *Reduction of Fear Thermometer ratings from 4 (very scared or worried) to 1 (happy, not scared at all).*

4. Describe intervention (s) selected:

   a. Child: *Counseling with the school psychologist. Teach developmentally appropriate coping strategies for Conner to use when he misses his mother/feels anxious. For example, talk to someone, go play with a friend, relaxation. Use of role play with puppets and stories to illustrate use of coping strategies.*

   b. Family: *Parent education about school refusal. Discussion of use of contingencies. Develop chart with rewards for appropriate morning behaviors (e.g., no crying). Parents to attend to other, positive behaviors and ignore minor somatic complaints. Parents to emphasize consistent bedtime and morning routines.*

Form continued on page 66

Form continued from page 65

c. School: *Teacher to welcome child in morning, engage him in doing special jobs. Teacher to ignore minor, somatic complaints with no apparent physical basis and pay attention to other, positive behaviors. Use of verbal praise. Teacher to help child engage with peers in activities during morning, unstructured play time. Teacher to keep chart for "no crying" and reward with stickers to be turned in for trinkets, playing a game with the school psychologist, etc.*

d. Consultation with medical personnel, community-based mental health professionals, and/or court-appointed case workers (include any community-based programs that will be implemented).

A recent medical evaluation found no apparent physical basis for Conner's somatic complaints.

5. Progress monitoring:

a. Who will be responsible for implementing the intervention(s)?

Teacher, school psychologist.

b. How will the effectiveness of the intervention be assessed? How often?

Daily frequency count of crying episodes. Weekly Fear Thermometer ratings.

c. Select date for follow-up meeting: *February 22, 2002*

6. Parent permission (when required):

____ I give my permission for the implementation of the intervention plan described above.

Parent or Legal Guardian	Date

CHAPTER 6

SUMMARY AND CONCLUDING COMMENTS

School psychologists are likely to encounter children who refuse school at any point during the year, though problems may be more frequent at the start of the school year and after weekends or holidays. Referrals may be as informal as a passing comment from a secretary or school nurse about a child's missing a lot of school to detailed and formal referrals from parents, teachers, or attendance officers. Anxiety-based school refusal affects approximately 2% of the school-age population, though some estimates are higher.

This book outlined the myriad and sometimes conflicting approaches to classification, assessment, and treatment that have accumulated over the years. What is clear is that rapid response and a multifaceted assessment and intervention approach is needed due to complex etiologic variables frequently associated with school refusal and the extreme heterogeneity that is the hallmark of this group of children. Components of assessment for school refusal behaviors may include child, parent, and teacher interview; observation; a thorough review of records and attendance history; behavior ratings; self-report measures; and functional assessment of the behaviors.

An overview of treatment studies revealed a recent emphasis on behavioral and cognitive-behavioral approaches involving several single and multiple case design/case study reports. Use of well-designed controlled studies investigating the effectiveness of cognitive-behavioral therapy for school refusers is accumulating, though further studies demonstrating its effectiveness are needed (King et al., 2000). There is increasing interest in refining treatment through a prescriptive approach that links intervention to the function of the child's school refusal behavior. A broad, functional approach addresses the extreme diversity of this population of children and is geared toward increasing efficiency for treatment selection and implementation. Studies investigating prescriptive treatment have provided preliminary evidence for determining which cognitive-behavioral strategy is more effective for which type of school refusal behavior (Kearney & Silverman, 1990, 1999).

The reasons why children refuse school range from anxiety and depression to learning problems to general defiance to a desire for attention. Severity lies on a continuum ranging from mild to severe and/or chronic cases that can be quite complex with regard to etiology. School refusal can be particularly distressing to parents, resulting in high levels of stress. Evidence suggests increased severity of symptoms for adolescent school refusers with comorbid anxiety and major depressive disorders, and further research to identify optimal length and type of treatment for this group has been suggested (Bernstein et al., 2000; Bernstein et al., 2001).

An important issue to be addressed is whether interventions used in clinical research settings, where much of the studies have been conducted, are effective when implemented within school settings. There have been several school-based studies investigating useful programs for truancy and drop-out prevention (e.g., Sinclair, Christenson, Evelo, & Hurley, 1998). Dadds, Spence, Holland, Barrett, and Laurens (1997) studied a school-based group cognitive-behavioral prevention and early intervention program for anxiety. Additionally, studies have documented the benefits of school-based cognitive-behavioral intervention for depression (Reynolds & Coats, 1986; Stark, 1990; Stark, Reynolds, & Kaslow, 1987).

However, while school psychologists are likely conducting interventions for school refusers (e.g., developing school re-entry plans, setting up contingencies, teaching coping strategies, consulting with teachers and parents), there is a lack of research on interventions for school refusal conducted within school settings. With increasing calls for school psychologists to implement evidence-based interventions for academic and behavior problems (e.g., Callan-Stoiber & Kratochwill, 2000), studies that investigate effective school-based practices for helping school refusers are needed. For example, school-based studies on functional assessment and/or cognitive-behavioral interventions for school refusal could help bridge the gap between research and school-based practice.

As with all interventions, acceptability issues will be an important consideration. For example, which intervention approaches (e.g., relaxation training, cognitive restructuring, setting up contingencies, and/or parent training) are school psychologists most likely to use for school refusal referrals?

School-based models for addressing school refusal have been described in the literature (e.g., Paige, 1993; Taylor & Adelman, 1990), and a problem-solving approach was suggested here. Problem-solving models have generated support within the profession of school psychology. Further research could investigate whether a problem-solving approach produces positive outcomes for school refusers.

With the growing awareness of the need for school-based and school-linked mental health services, schools are being asked to take increased responsibility with regard to prevention and intervention for emotional and behavioral problems (Pluymert, 2002). Graduate training and continuing education for school psychologists should include training in best practices for assessment and intervention for school refusal. School psychologists can take the lead in prevention, early intervention, and coordinating services for school refusers. Prevention activities for school refusal include inservice presentations and consultation support for teachers, administrators, and support staff emphasizing how to identify early warning signs and the need for timely response to the problem. Prevention for school refusal may also involve teaching children coping skills, assertiveness, and social skills training on a class-wide or individual basis. Systemic efforts may be needed to address school or district-wide issues such as school climate improvement and/or implementation of anti-bullying policies and programs.

School psychologists, by virtue of training and expertise, are well suited to provide early intervention for school refusal. Early intervention is often aimed at preventing problems from moving from mild to severe through interventions such as teacher consultation, teaching coping strategies, setting up contingencies, and/or working with parents. When school refusal is considered severe and chronic, implementation and/or coordination of more intensive, child- and family-based treatment is needed.

Finally, school psychologists can advocate for mental health services for students in those schools where services are inadequate or nonexistent. A team-based approach with collaboration between school, family, medical, and community-based service providers is critical for helping children with school refusal. For efforts to be successful, a sound knowledge base and persistence are required.

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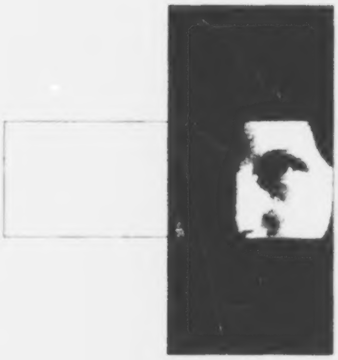

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The authors provide a format for addressing academic, social, and behavior problems based on a problem-solving model. The program provides protocols for implementing problem-solving consultation and progress monitoring procedures. The charts provided are especially useful for tracking and evaluating progress of interventions.

Kearney, C. A. (2001). *School refusal behavior in youth. A functional approach to assessment and treatment.* Washington DC: American Psychological Association.

The author provides extensive review of the history and current status of etiology, classification, assessment, and treatment of school refusal behavior and then addresses the problem of school refusal behavior from a functional perspective. Recognizing the heterogeneity of this population, four types of school refusers based on the function of the behavior are identified. Prescriptive treatment for school refusal behavior is described in detail. Comprehensive review of school, family, and community variables contributing to school refusal behavior is provided. The book contains case examples and a glossary of terms associated with school refusal behavior.

Kearney, C. A., & Albano, A.M. (2000). *When children refuse school: A cognitive-behavioral therapy approach: Therapist guide.* San Antonio, TX: The Psychological Corporation.

This therapist guide outlines specific cognitive-behavioral procedures for mental health professionals to use when treating school refusal behavior. It describes a functional model for assessment of school refusal. Prescriptive cognitive-behavioral treatments are described so that procedures can be implemented by practitioners. A parent workbook is also available.

King, N. J., Ollendick, T. H., & Tonge, B. J. (1995). *School refusal: Assessment and treatment.* Boston: Allyn & Bacon.

The authors provide an overview of school refusal and diagnostic considerations. Behavioral assessment and treatment are outlined and case examples are provided. The use of pharmacotherapy for school refusal is covered in detail. Practical suggestions for school personnel to use to help school refusers are outlined.

Paige, L. Z. (1993). *The identification and treatment of school phobia.* Silver Spring, MD: National Association of School Psychologists.

This is a practical manual that provides the user with information on etiology of school refusal, as well as assessment, and intervention strategies. Decision matrices are provided for school-based practitioners to use when assessing and planning interventions. School-based case illustrations and handouts for teachers and parents are provided.

Paige, L. Z. (1997). School phobia, school refusal, and school avoidance. In G. G. Bear, K. M. Minke, & A. Thomas (Eds.), *Children's needs II: Development, problems, and alternatives* (pp. 339–347). Bethesda, MD. National Association of School Psychologists.

This chapter outlines school refusal from an historical perspective. It analyzes the various terms used to describe school refusal and their diagnostic distinctions. Practical information is provided for the school practitioner involved in assessing and planning interventions.

APPENDIX A: SAMPLE ASSESSMENT FORM FOR SCHOOL REFUSAL BEHAVIOR

Name: ______________________ Grade: ______________________

DOB: ______________________ Date: ______________________

1. Identify primary concerns.

2. Describe the frequency of the school refusal behavior. Include number of absences, days tardy, and/or frequency of conflicts with school staff or parents regarding school attendance.

3. Summary of assessment data (e.g., interview, observations, self-report measures, behavior ratings). Include relevant information regarding emotional/behavioral functioning, skill deficits, medical, school, family, and/or stressful life events.

4. Describe student's strengths (support system, within child factors).

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5. Describe antecedents to the behaviors. What happens before the behavior occurs?

6. Describe the consequences. What happens after the behavior occurs? Identify possible functions of the behavior.

APPENDIX B: SAMPLE INTERVENTION PLANNING FORM FOR SCHOOL REFUSAL BEHAVIOR

Name: ______________________ Grade: ______________________

DOB: ______________________ Date: ______________________

1. Summarize assessment data. Include emotional/behavioral characteristics, skill deficits, medical, school, family, and/or stressful life events contributing to the behavior.

2. What appears to be the cause or function of the school refusal behavior; for example, to escape or avoid an anxiety producing situation, to gain attention, to obtain a desired activity?

3. Select goals (e.g. increase attendance, increase coping skills).

4. Describe intervention (s) selected:

   a. Child:

   b. Family:

Continued on page 88

Continued from page 87

c. School:

d. Consultation with medical personnel, community-based mental health professionals, and/or court-appointed case workers (include any community-based programs that will be implemented).

5. Progress monitoring:

   a. Who will be responsible for implementing the intervention(s)?

   b. How will the effectiveness of the intervention be assessed? How often?

   c. Select date for follow-up meeting:

6. Parent permission (when required):

____ I give my permission for the implementation of the intervention plan described above.

Parent or Legal Guardian

Date

APPENDIX C: SCHOOL REFUSAL HANDOUT

WHAT IS SCHOOL REFUSAL?

School refusal refers to children who refuse to go to school usually because of anxiety and occurs in approximately 2% of school-age children, though some estimates are higher. School refusal includes those children who miss all or part of the school day and/or act out (e.g., cry, complain) about going to school (Kearney, 2001). School refusal refers to behaviors previously associated with the term "school phobia." The term "school refusal" is often used because it encompasses the many reasons why children refuse school. The broader term, "school refusal behavior," refers to children with anxiety-based school refusal as well as those traditionally referred to as truant (Kearney, 2001). Children commonly referred to as truant skip school without their parents' knowledge and do not demonstrate the emotional difficulties typical of children with anxiety-based school refusal.

School refusal is associated with various types of anxiety including:

- Anxiety about separation from a parent
- Anxiety about socializing with other students
- Severe anxiety about performance situations (giving speeches, taking tests, athletic performance)
- General worries about events or situations
- Specific phobias

High rates of anxiety disorders have been found in school-refusing children, and depression may also be present for some children. Other school refusers have no diagnosable emotional disorder. School refusers are likely to have frequent physical complaints with no apparent medical basis though the physical complaints clearly distress the child (e.g., stomachaches, headaches). Contributing to school refusal may be medical, family, or school factors or stressful life events. School situations that may trigger school refusal are when a child is teased, bullied, or physically threatened. Some warning signs of school refusal are:

- Frequent unexcused absences
- Frequent tardiness

- Absences on significant days (tests, speeches, physical education class)
- Frequent requests to call home
- Worrying about a parent while in school
- Frequent requests to go to the nurse's office because of physical complaints
- Crying about wanting to go home

Severity of school refusal behavior ranges from mild to severe. School refusal has been found to occur more often following holidays or weekends and at the start of a new school year. Rates tend to peak around early adolescence, with higher rates occurring around major changes in children's lives such as kindergarten entry or the move from elementary to middle school. Potential consequences associated with prolonged school refusal are lack of academic progress, failure to develop satisfactory social relationships, significant family conflict, and adult affective disorders.

HOW IS SCHOOL REFUSAL ASSESSED?

School refusal may be a result of many factors. Therefore, assessment should involve a variety of methods and sources and should include information gathered across more than one setting. Assessment tools for school refusal include:

- Interview
- Observation
- Thorough review of records and attendance history
- Self-report measures
- Behavior rating scales
- Functional behavioral assessment and analysis

A functional assessment of the reasons for the school refusal behavior is accomplished by examining antecedents and consequences to the behavior (what happens before and what happens after). Kearney and Sliverman (1990, 1999) have outlined four functions or reasons why children refusal school:

- To avoid situations that result in negative affectivity (fear, anxiety, depression, and/or somatic complaints)
- To escape aversive social or evaluative situations
- For attention
- To pursue a desired activity (e.g., watch television, play video games, hang out with friends)

Children may refuse school for more than one reason. Assessment is geared toward uncovering the reasons behind the school refusal to determine the most appropriate intervention for the type of school refusal behavior shown by the child. A collaborative team approach between school, family, and medical- and community-based service providers is recommended. In school settings, school refusal can be addressed within the context of problem solving or student intervention teams.

INTERVENTIONS FOR SCHOOL REFUSAL

Behavioral and cognitive-behavioral interventions are frequently used for helping children overcome school refusal including:

- Relaxation training and systematic desensitization
- Cognitive restructuring
- Social skills training
- Contingency management
- Parent training
- Gradual exposure to school

Other interventions include psychoeducation (teaching about anxiety), teacher consultation, and goal-setting. Interventions selected should be based on the type of school-refusal behavior; for example, teaching relaxation to children who are fearful about being separated from a parent or providing tutoring for children with academic difficulties.

FORCED SCHOOL ATTENDANCE OR GRADUAL RE-ENTRY?

Much has been written about whether to use a forced school attendance approach or implement a process of gradual re-entry to school. The advantages of forced school attendance are that secondary reinforcement of staying home is reduced and children have less time to develop negative feelings about coming back to school (e.g., worrying about what others at school will say to them). Forced school attendance and parent training may be appropriate for children with mild school refusal, younger children, and/or children who have missed school for less than two weeks (Kearney & Albano, 2000; Kearney & Beasley, 1994). However, because forced school attendance can be so stressful for all involved, a gradual re-entry to school is often used. For older children and for those who are extremely anxious or depressed, a gradual school re-entry process is generally recommended (Kearney & Albano, 2000).

HOW CAN TEACHERS AND PARENTS HELP?

Teachers can help children who are anxious about separating from a parent by:

- Welcoming the child when the child comes to school
- Giving the child special jobs to do in the morning
- Ignoring negative behaviors (crying, whining)
- Ignoring minor physical complaints that have no apparent medical basis
- Reinforcing positive behaviors (King et al., 1995)

A peer buddy or mentor can help separation or socially anxious children feel more comfortable at school. Teachers can help children who have performance anxiety by showing sensitivity surrounding performance situations such as giving speeches or athletic competition. Parents may need to review effective parenting strategies for managing school-refusal behaviors such as use of contingency management and developing smooth morning and evening routines (Kearney & Silverman, 1999).

IMPORTANCE OF QUICK RESPONSE TO SCHOOL REFUSAL

The goal of intervention for school refusal should be to increase school attendance, to increase the child's coping skills, and to decrease school refusal behaviors. Efficient assessment and intervention for school refusers is important since timely response has been linked to positive outcomes. Further information about school refusal can be found in this book as well as in the annotated bibliography provided.

FURTHER SUGGESTED READINGS

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Anxiety-based school refusal occurs in 2% of school-age children. The reasons why they refuse to go to school range from mental illness and learning problems to general defiance and a desire for attention. Research clearly indicates that early identification and multi-faceted assessment and interventions are critical to addressing the complex variables associated with the problem and the extreme heterogeneity that is the hallmark of this population of children.

Presented in a readable, "hands-on" format, *School Refusal* offers concise, practical guidance on assessment and interventions to help children with anxiety-based school refusal. Author Mary Wimmer incorporates the latest research findings and discusses causes, warning signs, and various strategies for working with children within a school setting and for communicating with parents and teachers. Chapters cover:

- Understanding school refusal
- History and etiology
- Identification and assessment
- Interventions
- Case illustration
- Sample forms and handouts

Every school psychologist needs this book. A great resource for practitioners, students, and interns as well as school counselors and social workers.

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ISBN 0-932955-81-9

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EFF-089 (1/2003)